

# NSW Health Frontline Procedures for the Protection of Children and Young People



NSW HEALTH DEPARTMENT

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# Foreword

NSW Health has a strong commitment to the safety, welfare and well being of children and young people. NSW Health services work in partnership with other key agencies to promote the protection of children and young people. The provision of Health services to children, young people and their families and carers is essential to protect children and young people from risk of harm.

NSW Government Departments have made a commitment to providing a coordinated and comprehensive response to promote the care and protection of children and young people. The Interagency Guidelines for Child Protection Intervention 2000, and the introduction of new legislation, policies and training are strategies implemented by the NSW Government to meet this commitment.

NSW Health Procedures for the Protection of Children and Young People operationalise the responsibilities of NSW Health under the Children and Young Persons (Care and Protection) Act 1998 and build on and incorporate existing good practice. All Health workers have a responsibility to recognise and report children in need of care and protection, and to provide appropriate services for those children and their families.

These procedures reflect the work of the Senior Officers Group for Child Protection, Health Services Policy Branch, the NSW Health EnAct Taskforce, and consultation with Area Health Services, NSW Health workers, and other Government Departments.

It is with great pleasure that I present the NSW Health Frontline Procedures for the Protection of Children and Young People. I encourage active participation from all levels of the health system, and collaboration with other key agencies to promote the safety, welfare and well-being of children, young people and their families in NSW.



Michael Reid  
**Director-General**

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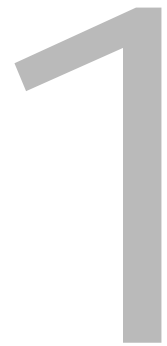
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# Introduction



NSW Health has a key role to play in the protection of children and young people. We provide a comprehensive range of services that enhance the health and well-being of children, young people and their caregivers and help to prevent abuse and neglect. Health workers are uniquely placed to support parents, caregivers and communities and promote the development of a safe and healthy environment for all children and young people.

Large scale Australian research indicates that one in three children experience abuse with 10% reported to experience severe beating and 28% child sexual assault involving physical contact (Mazza, Dennerstein, and Ryan 1996). As children make up 25% of the population of NSW (ABS 1999), this represents a significant number who are at risk of abuse at any time. For example in 1998/99, the Department of Community Services dealt with 10,000 cases of abuse or neglect of children in NSW (DOCS 1999).

Not all abuse against children is identified at the time it occurs and there is increasing recognition that child abuse can have severe health impacts in both the short and long term. US research indicates that childhood experiences of abuse and neglect show a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures and liver disease (Felitti, Anda, Nordeberg et al 1998). Health services have an important role to play in reducing these effects.

Every Health worker that comes into contact with children has a responsibility to protect the health, safety and welfare of these children. It is important that all Health workers are able to recognise child abuse and neglect and know what action to take to ensure that children are protected.

These procedures provide information to help you recognise children at risk of harm, make a report to the Department of Community Services, respond to requests for service, and exchange information with the Department of Community Services.

They are targeted at all frontline health professionals including those working in the following areas:

- emergency departments
- other hospital facilities
- maternity departments
- early childhood nursing services
- nurses in schools
- public oral health services
- community health centres
- child, adolescent and family services
- youth health services
- PANOC (Physical Abuse and Neglect of Children) specialist services
- sexual assault services
- drug and alcohol services
- child and adolescent mental health services
- adult mental health services
- sexual health services
- needle and syringe program services.

The procedures are consistent with the Interagency Guidelines for Child Protection Intervention 2000 and represent a clear commitment on the part of NSW Health to work cooperatively with other agencies to maximise the health and protection of children and young people affected by physical abuse, sexual abuse, emotional abuse and neglect.

These procedures replace the NSW Health policy *Protecting Children and Young People from Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect, and Recognising and Notifying Child Abuse and Neglect*. (1997)

# 2

## The Policy Context

In 1998 the Children and Young Persons (Care and Protection) Act 1998 was passed by the NSW Government. This Act creates new responsibilities for health services.

NSW Health has also been involved in the development of the *Interagency Guidelines for Child Protection Intervention 2000* which describe the NSW Government's commitment to child protection and provide agreed principles for intervention and interagency cooperation. As a signatory to these interagency guidelines, NSW Health is committed to supporting their full implementation. The following extracts from the guidelines explain these shared principles.

### 2.1 Child Protection: The Whole of Government Approach

The NSW Government believes that one of the primary concerns of any community should be the health and well-being of its children and young people. Children and young people should be able to grow up in an environment that enables them to develop physically, emotionally, intellectually and socially in conditions of freedom and dignity.

The NSW Government is committed to a coordinated and comprehensive response to promote the protection of children and young people. Effective care and protection incorporates community action to:

- prevent and reduce the abuse and neglect of children or young people in the community
- provide support to families experiencing difficulties so their circumstances change
- respond to reports of risk of harm so that the safety of children and young people is effectively addressed and appropriate support is provided
- ensure offenders are appropriately sanctioned.

The Government recognises that there are common features that enable consistent procedures to be developed and implemented within a good practice framework. It also recognises that physical abuse, emotional (psychological) abuse, neglect and child sexual assault will require different and specialised responses.

While other agencies have key roles in child protection, the Department of Community Services has the statutory mandate to coordinate responses and to ask other agencies to provide appropriate care and support to children, young people and their families.

### 2.2 Principles for Child Protection Intervention

The NSW Government has adopted the following principles to guide agency decisions on child protection and provide a framework for individual agency policies, practices and procedures.

- The safety, welfare and well-being of the child or young person are paramount.
- Children and young people must be given the opportunity to participate at a level appropriate to their age and development in decisions which significantly impact on their lives.
- Child protection decisions must take account of the culture, disability, language, religion and gender of the child or young person, their family and caregivers.
- Families must be given an opportunity to participate in decisions which affect the safety, welfare and well-being of a child or young person.
- In acting to protect a child or young person, practitioners or agencies should maintain the child or young person's relationships and sense of identity and should intervene only as far as required to secure their safety, welfare and well-being.

- Children and young people who are unable to live with their families will be provided with an environment which meets their care, support, education and health needs.
- Government agencies will work in partnership with each other, with non-government organisations and with the child or young person and their family to secure and sustain their safety, welfare and well-being.
- Government and non-government agencies will follow policies and practices that ensure staff are screened for employment and are qualified, trained and supervised.

## 2.3 Interagency Cooperation

As a basis for interagency child protection work, it is expected that practitioners and agencies will share:

- an understanding of the aims of intervention and of what is good practice
- an appreciation of and respect for different roles and different contributions of practitioners
- a commitment to partnership between the government and non-government sectors in achieving good practice responses
- an understanding of the context in which agencies work and acknowledgment of their constraints
- a preference for coordinated effort rather than unilateral action by a single agency or uncoordinated action by a number of agencies
- a willingness to learn from each other
- a belief in accountability to clients, to each other, and to the community.

In carrying out their duties, practitioners and agencies will be conscious of:

- a child or young person's immediate needs as well as assessed longer term needs for safety, nurturing and specialised assistance
- the need for prompt and purposeful information exchange between agencies in the interests of the immediate and ongoing safety of the child or young person
- clear division of responsibilities for the practitioners and agencies involved
- the importance of a case manager for every case
- the importance of following the processes for interagency planning in assessments and investigations in order to minimise trauma to families and protect the best interests of children and young people
- the need to deal constructively and promptly with difficulties and differences resulting in conflict between agencies
- differing experiences of child abuse and neglect for individuals that require individually planned responses.

# 3

## The role of NSW Health and the Department of Community Services in Child Protection

### 3.1 Introduction

Health workers are uniquely placed to recognise children who may be experiencing child abuse or neglect and intervene to protect them. By accurately recognising and documenting cases of suspected or actual child abuse, Health workers play an important role in supporting children and putting in place a process to address the concerns raised.

NSW Health is committed to ensuring that children who are suspected of being abused receive care and protection of the highest quality. It has been recognised that some children have experienced what has become known as 'systems abuse' by government agencies involved in their protection. In relation to Health, this 'abuse' could take the form of excessive delays before receiving treatment, a failure to make a report, repeated interviewing of a child or lack of access to appropriate specialist services.

### 3.2 The need for an interagency approach

Protecting children from abuse and neglect is a shared responsibility. The complexity of the problem of child abuse and neglect means that effective intervention requires an understanding of the different roles and responsibilities of the various agencies which respond to child abuse.

### 3.3 Lead responsibility

The Department of Community Services is the agency with lead responsibility in child protection because it is charged by law with responsibility for the statutory care and protection of children. The Department has wide powers to enable it to carry out this responsibility on behalf of the community. While other agencies have key roles in child protection, the Department of Community Services has the responsibility and legal mandate to ensure the child's safety, welfare and well-being. This lead responsibility does not however detract from all agencies working together to protect children.

### 3.4 Role of NSW Health

The Interagency Guidelines for Child Protection Intervention 2000 describe the roles of all key government agencies in relation to children and young people who have experienced abuse.

The role of NSW Health in child protection is to recognise and report children and young people who are at suspected risk of harm from abuse and neglect and to provide crisis counselling, ongoing counselling and medical examinations for children and young people who have experienced abuse or neglect. NSW Health offers preventative and educational programs for health workers and communities as well as special programs for children, young people and families who have experienced child abuse or neglect.

### 3.5 Responsibilities

As a service provider:

- Providing medical examinations including a developmental assessment for children and young people where there is an allegation of physical or sexual abuse or neglect.
- Providing psychosocial, psychiatric and developmental assessment of children and young people suspected of emotional abuse or neglect.
- Providing medical treatment to children and young people where abuse or neglect has been identified.
- Providing crisis and ongoing counselling and advocacy services for children and young people who have been sexually abused, their non-offending caregivers and siblings at Sexual Assault Services.
- Providing counselling for eligible child sexual offenders through the Pre-Trial Diversion of Offenders Program.

- Providing counselling (through NSW Health Department prescribed programs) for young people who have committed sexual offences and who are not eligible for programs provided by the Department of Juvenile Justice.
- Providing counselling for children under the age of ten who are exhibiting sexualised or sexually abusive behaviour.
- Providing counselling for children and young people (who have been physically abused, emotionally abused or neglected) and their families through Physical Abuse and Neglect of Children (PANOC) services.
- Providing court preparation and support to children and young people who have experienced abuse and to their non-offending caregivers.
- Maintaining a victims register with the Mental Health Review Tribunal.
- Providing a range of health responses to children and young people where these are indicated including medical treatment, mental health services, health screening and community health services.
- Providing preventative programs, including early intervention services, for the community that aim to protect children and young people.

As an employer:

- Ensuring all frontline health workers, their managers and other relevant staff are aware of their obligations to report suspected risk of harm, procedures for reporting and the implementation of care and support action.
- Ensuring all frontline health workers, their managers and other relevant staff are aware of the indicators of child abuse and neglect.
- Providing training and supervision for staff in the recognition and reporting of suspected risk of harm and in the implementation of the Department's child protection policy and procedures.
- Conducting the Working With Children Check.
- Reporting to the Ombudsman any child abuse allegations/convictions made against an employee, and ensuring that the allegations/convictions made against the employee are investigated and appropriate action taken.

As a funding and regulatory body:

- Advising organisations funded by NSW Health of their responsibilities to protect children and young people.
- Informing non-government organisations funded by NSW Health about Working with Children Check obligations and assisting them in carrying out these obligations.

As an interagency partner:

- Exchanging relevant information to progress investigations, assessments and case management as permitted by law.
- Working with other government and non-government agencies within agreed, coordinated procedures, to plan and provide services for the care and protection of children and young people, and to strengthen and support families.
- Using best endeavours in responding to requests for services from the Department of Community Services provided the request is consistent with departmental responsibilities and policies.
- Providing the Working with Children Check services to groups and agencies in the health sector.

### 3.6 Other agencies roles and responsibilities

Roles and responsibilities have also been agreed for other government departments and agencies. These roles are outlined in the Interagency Guidelines for Child Protection Intervention (2000 edition).

### 3.7 NSW Health framework for protecting children and young people from abuse

Child protection systems have undergone considerable change over the past ten years with an increased recognition of the need for early intervention and prevention for a range of forms of abuse. Providing appropriate care and assessment before a child is born can help prevent abuse. It is also increasingly recognised that practitioners who work with adults may have responsibilities to the children of their clients.

Health services need to be delivered within a framework that acknowledges the complexity of child abuse and neglect and identifies the points at which health services are best placed to contribute to child protection. For this reason, NSW Health provides primary, secondary and tertiary based services for children, young people and their families and caregivers.

Primary prevention services are programs offered to the whole community (both children and adults) with the aim of preventing the abuse before it starts.

Secondary services are also programs designed to prevent abuse but in this case the programs target specific sections of the child population considered to be more 'at risk' of being abused, and specific sections of the adult population considered to be more 'at risk' of abusing.

Tertiary services refer to intervention to help those who have already been abused, with the aim of stopping further abuse and preventing the development of longer term difficulties.

### 3.8 Primary services

NSW Health provides a wide range of services to support parents and caregivers and enable them to provide adequately for the health and well-being of their children. An example of a health service which offers primary prevention is the statewide network of early childhood centres. They provide a universal, non-stigmatising health service offering support to families at the early stage of parent-child relationships. NSW Health also offers services such as antenatal screening for risk factors, antenatal education, postnatal groups, parenting groups for children at challenging development ages (eg toddlers) and positive parenting programs.

NSW Health is committed to implementing the Families First strategy in all Area Health Services. The broad aim of this strategy is to support parents and caregivers raising children. Families First identifies the importance of supporting parents through pregnancy and following the birth of their children and aims to link parents as soon as possible to appropriate support services. This early identification of support needs and risk issues is a significant strategy in the prevention of abuse. Practice guidelines for home visiting services, data collection systems and effective screening tools support the Families First strategy.

Health promotion services can also play an important role in changing attitudes towards children through community education about preventing accidental injuries, the harm associated with physical punishment, and skills for positive, non-coercive relationships. Community education campaigns about domestic violence also help to prevent harm to children and young people who may suffer abuse from exposure to violence at home.

### 3.9 Secondary services

NSW Health offers a broad range of secondary prevention services including family care cottages, groups for women experiencing post-natal depression, community midwives, and antenatal and postnatal groups for young, single or homeless mothers.

Clinical experience indicates that an increasing proportion of children entering the child protection system have parents who are potential or actual clients of health services such as drug and alcohol, mental health and developmental disability services. The provision of essential services to adults who are parents has an important protective function for children and young people.

The early identification of domestic violence through assessment at critical entry points into the health system offers an important targeted preventive intervention for children who may suffer serious effects from living in households where violence occurs. Providing services to women in response to domestic violence is an important secondary preventive intervention.

The vulnerability of all children to contact with child sexual assault offenders makes it difficult to develop services for potential victims. Since sex offenders commonly know the child and family, they are skilled at tailoring their tactics of entrapment to the unique vulnerabilities of the potential child victim, making any child potentially a victim. Health services can play a role in secondary prevention by offering services which help children to deal with common life difficulties, such as the stress of parental separation and divorce, when they may be particularly vulnerable to sex offenders who choose to target them (Daro, 1994). In addition any health services which help children, young people and their families to develop open lines of communication can play a role in undermining the divisiveness which offenders foster between children and their non offending caregivers.

### 3.10 Tertiary services

Providing appropriate health services to adults whose children have been abused is an important tertiary prevention strategy. Drug and alcohol, mental health and disability services all have essential roles to play by enhancing the capacities of adults who are parents and caregivers.

### 3.11 Responding to physical abuse, emotional abuse and neglect

A range of health programs provide services to children, young people and their families or caregivers where physical abuse, emotional abuse or neglect have occurred. These services include three Level 6 Child Protection Units in teaching hospitals which provide a specialist response to children and young people who have experienced abuse.

Physical Abuse and Neglect of Children (PANOC) specialist services based in each Area Health Service provide a range of therapeutic, counselling and casework services to children, young people and their families when physical abuse, emotional abuse, neglect or exposure to domestic violence has occurred within the family. Intervention is specialised and complex because the abuser is most commonly the child or young person's caregiver and the goal is to maintain the child or young person in their family where possible. Current approaches to treatment emphasise the need to try to establish open, respectful partnerships with parents to increase their competency and confidence as parents. PANOC services may also work with the perpetrator of domestic violence around child protection issues.

Referrals for children, young people and their families to specialist PANOC services can only be made by the Department of Community Services or Joint Investigation Teams/Responses. Where appropriate, referrals can also be accepted from some courts.

PANOC specialist services also provide consultation and support for Health workers on child protection issues and concerns as well as education and training about child protection issues.

PANOC services are provided by a range of different Health services including Early Childhood Services, Child and Family Teams and Mental Health services.

### 3.12 Responding to child sexual assault

NSW Health has a network of Sexual Assault Services that deliver crisis and ongoing treatment to victims of child sexual assault and their non-offending caregivers. These services provide a specialist response to children where sexual abuse has been positively identified. They also provide medical examinations and treatment, crisis and ongoing counselling for the child and their non-offending parents and siblings, information and advocacy, court preparation and support, and community and professional education.

Specialist sexual assault counsellors are experienced in working with the multiple agencies which intervene in cases of child sexual assault. A variety of treatment modalities are offered including individual, family, group, and non-offending parent-child counselling. The aim of the treatment is to address the impact of the abuse on the child and non-offending family members so that long term emotional and social difficulties are less likely to develop. This includes addressing the emotional impacts (such as fear and shame), interpersonal impacts (such as isolation and stigmatisation), and ensuring that responsibility is attributed to the offender. This helps to reduce self-blame and rebuild relationships with non-offending family members.

If sexual assault has not been positively identified but a health service is considered appropriate to assist a child or parent, referral may be made to an appropriate Child and Family Health Service. NSW Health Sexual Assault Services operate in accordance with the Child Sexual Assault Procedure Manual.

### 3.13 Responding to children under ten years who exhibit sexually offending behaviour

Area Health Services are responsible for providing services to children under the age of 10 years who are exhibiting sexualised or sexually offending behaviour. Services for children who have also been victims of sexual assault are provided by Sexual Assault Services. Services for children who have not been a victim of sexual assault are provided by trained Child and Family and Child and Adolescent Mental Health workers. The Education Centre Against Violence provides training and resources for this area of work.

This response is available through both Sexual Assault and Child and Family Services in a range of locations in the area. An Area Coordinator provides quarterly data to the Department of Health and coordinates the provision of training for staff.

### **3.14 Responding to children and young people aged ten and over who sexually assault other children**

NSW Health provides counselling through specific programs for children and young people over the age of 10 years who have committed sexual offences and are not eligible for programs provided by the Department of Juvenile Justice. Currently these services are New Street located at Western Sydney and Trek located on the Central Coast. These designated services are supported by a Memorandum of Understanding with key government departments and an interagency advisory committee.

### **3.15 Responding to adult perpetrators of sexual abuse**

Sexual assault is criminal behaviour and is of a particularly complex and intractable nature. Because of this, working with adult sexual assault offenders is a specialised area of practice.

Health services do not have a role in providing treatment to adult sexual assault offenders because they are dealt with by the criminal justice system. The only exception is the NSW Pre-Trial Diversion Program at Westmead. This is a specialised program which treats eligible adult sexual offenders who have sexually assaulted their own or their partner's children and who plead guilty in criminal court.

# Recognising abuse and neglect of children and young people: Definitions

# 4

There are many clinical situations where good practice demands that we ask ourselves the basic question:

*'Is this a situation where the child or young person may have been abused or neglected or is at risk of harm?'*

## 4.1 Defining child abuse

Every Health worker should have a clear understanding of the main points of the law that apply to the safety, welfare and well-being of children and young people and the implications these points of law have for the discharge of their responsibilities.

The legal context of child abuse and neglect is set out in a number of Acts of Parliament. The law covers three main areas. The care and protection of children as provided for in the *Children and Young Persons (Care and Protection) Act 1998*, the criminal law as set out in the *Crimes Act 1900*, and employment screening which is covered by the Child Protection (Prohibited Employment) Act 1998, the Commission for Children and Young People Act 1998, and the Ombudsman Amendment (Child Protection and Community Services) Act 1998.

Child abuse is a term commonly used to refer to different types of maltreatment inflicted on a child or young person. It includes assault (including sexual assault), ill treatment and exposing the child or young person to behaviour that might cause psychological harm. Child abuse can be a criminal offence under the Crimes Act 1900.

## 4.2 Definition of a child

Section 3 of the *Children and Young Persons (Care and Protection) Act 1998* defines a 'child' as a person who is under the age of 16 years.

## 4.3 Definition of a young person

Section 3 of the Children and Young Persons (Care and Protection) Act 1998 defines a 'young person' as a person who is aged 16 years or above but who is under the age of 18 years.

## 4.4 Definition of a class of children or young people

The *Interagency Guidelines for Child Protection Intervention 2000* define a class of children or young people as more than one child or young person who may be at risk of harm from abuse because of a person or situation. An example may be the children in a school or recreational group where a person in charge is suspected of abuse or known to have abused a child.

## 4.5 Risk of harm

Under section 23 of the Children and Young Persons (Care and Protection) Act 1998, a child or young person is at risk of harm if current concerns exist for the safety, welfare or well-being of the child or young person because of the presence of any one or more of the following circumstances:

- (a) the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met
- (b) the parents or other caregivers have not arranged and are unable or unwilling to arrange for the child or young person to receive necessary medical care
- (c) the child or young person has been, or is at risk of being, physically or sexually abused or ill-treated
- (d) the child or young person is living in a household where there have been incidents of domestic violence and, as a consequence, the child or young person is at risk of serious physical or psychological harm
- (e) a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm.

## 4.6 What is risk of harm?

Risk of harm refers to the likelihood that a child or young person may suffer physical, psychological or emotional harm as a result of what is done (physical, sexual or emotional abuse) or not done (neglect) by another person, often an adult responsible for their care. Risk of harm can also refer to young people who may suffer physical, psychological, sexual or emotional harm as a result of environmental factors (for example homelessness) or self-harming behaviours.

A child who is injecting drugs is at risk within the current legal and policy framework and should be the subject of a report to the DoCS Helpline in addition to a referral to drug and alcohol services. If the name of a client is not known, Health workers are obliged to meet their reporting obligations by providing the Department of Community Services with a description of the client and any other identifying information. It is important to note that sterile injecting equipment should be made available to any person who is currently involved in injecting drugs, regardless of their age.

Health workers are required to make professional judgements about risk of harm to a child or young person from abuse or neglect. This means considering the likely degree of harm taking into account the age, development and vulnerability of the child or young person.

## 4.7 Key points in assessing risk of harm

There are a number of factors that Health workers should consider when deciding whether a child or young person is at risk of harm from abuse or neglect.

These factors may include:

- the age, development, functioning and vulnerability of the child or young person
- the behaviour of the child or young person which suggests they may have been or are being harmed by another person
- the behaviour of another person that has had, or is having, a demonstrated negative impact on the healthy development, safety, welfare and well-being of the child or young person, for example drug and alcohol abuse or domestic violence

- contextual risk factors such as recent abuse or neglect of a sibling or a parent recently experiencing significant problems in managing the child or young person's behaviour
- indications that the child or young person's emotional, physical or psychological well-being are significantly affected as a result of abuse and neglect
- factors that may help reduce risk of harm and provide protection such as nurturing, affectionate and secure relationships with at least one parent and another adult, positive school environments and pro-social peer groups, and positive personal achievements.

A range of socioeconomic factors such as poverty, the presence or absence of educational opportunities, social support and social isolation may also influence both the level of risk and degree of harm. These factors do not of themselves constitute risk of harm in relation to section 23 of the Act but might influence a judgment on both the level of risk and the degree of harm that may occur.

The evidence of harm may arise from one event, a series of events over time, or an accumulation of circumstances or behaviour causing concern.

## 4.8 What are current concerns?

A current concern means that, at the time of making a report, a Health worker is worried about the safety, welfare or well-being of a child or young person. A Health worker may also have concerns about a class of children, that is other children or young people who have current contact with an alleged abuser.

Current concerns may also exist for a child or young person where abuse has happened in the past and the child or young person may be at risk because of their current reaction to the abuse. Sexual abuse of a child should be reported to the Department of Community Services to enable referral to appropriate services and consideration of criminal issues.

## 4.9 About neglect (section 23 a)

Neglect occurs where there is risk of harm or actual harm to a child or young person caused by the failure to provide the basic physical and emotional necessities of life. Neglect may be an ongoing situation and can be caused by a repeated failure to meet the basic psychological needs of a child or young person.

### Neglect of basic physical needs

This is when a parent or caregiver fails to provide the basic staples of life to an adequate degree. These include food, physical support and hygiene. It also includes safety from harm which may include providing appropriate and adequate adult supervision.

### Neglect of basic psychological needs

This is when a child or young person does not receive sufficient or appropriate interaction, encouragement, nurturing or stimulation from their parent or caregiver. Neglect also refers to the persistent ignoring of a child's signals of distress such as pleas for help, attention, comfort, reassurance, encouragement and acceptance. In young people this may include disinterest in all aspects of a young person's life by the parent or caregiver.

## 4.10 About necessary medical care (section 23 b)

Risk of harm may include circumstances where the parents or caregivers have not arranged and are unable or unwilling to arrange for a child or young person to receive necessary medical care. Health workers need to consider whether risk of harm is likely to arise from a failure to arrange this medical care. For very young children, the risk of harm in not receiving medical attention may be quite high. There are some conditions for which parents may not seek medical care, but do not pose a risk of harm to the child. Other conditions such as burns may be quite critical and, depending on severity, require medical attention.

Some forms of medical intervention, such as immunisation, are widely debated in the community and would not be included within the definition of necessary medical care. Cultural or parental beliefs may lead a parent or caregiver to decide on a particular course of treatment for a condition. If these decisions do not result in a child or young person being deprived of necessary medical care, a report to the Department of Community Services is not necessary.

## 4.11 About physical abuse or ill-treatment (section 23 c)

Physical abuse or ill-treatment is assault, non-accidental injury or physical harm to a child or young person by a parent, caregiver, other person responsible for the child or young person, or a sibling or other child or young person in the household. It includes injuries or harm which are caused by excessive discipline, beating or shaking, bruising, lacerations or welts, burns, fractures or dislocation, female genital mutilation, attempted suffocation or strangulation. All of these may result in the death of a child or young person.

Physical abuse may constitute criminal assault. The circumstances of the victim, including the vulnerability of the child or young person and the likelihood of them sustaining a serious or permanent injury, means that assault charges may be warranted in cases of physical abuse.

Female genital mutilation is a crime under the Crimes Act. The Crimes (Female Genital Mutilation) Act 1995 states that anyone who is found guilty of practising female genital mutilation or who aids, abets, counsels or procures someone else to practise female genital mutilation on another person is liable to a prison sentence of up to seven years. It is also illegal for female genital mutilation to be carried out overseas on any person who is normally a resident in New South Wales.

## 4.12 About sexual assault or ill-treatment (section 23 c)

Sexual assault and indecent assault are crimes under the NSW Crimes Act.

Sexual assault includes any sexual act or sexual threat imposed on a child or young person. Adults, adolescents or older children who sexually assault children or young people exploit their dependency and immaturity. Coercion, which may be physical or psychological, is intrinsic to child sexual assault and differentiates it from consensual sex with a peer.

Careful consideration is necessary because although a child or young person may perceive sexual activity as consensual because of the way the other person involved has promoted it, the situation may be one of sexual abuse and exploitation. The apparent consent of a child or young person may not mean that abuse did not occur.

It is important to report sexual assault that has happened to a child or young person in the past if the alleged perpetrator still has contact with children. For example, if the alleged perpetrator has current contact with a child or young person in a family setting or is a teacher or works with young people.

Children and young people may exhibit sexually offending behaviour. A child who is exhibiting sexually offending behaviour should be considered at risk of harm. If Health workers have reasonable grounds to suspect that a child or young person is exhibiting sexually offending behaviour, they should make a report. This should occur even if a victim has not been identified.

Research shows that children do not always manifest obvious current effects following serious abuse and disclosure of abuse is often delayed. Therefore a child or young person who has experienced past serious abuse, including sexual abuse, should be considered at risk of harm even if there does not appear to be obvious current concerns. Reporting such abuse enables follow up by employers if the alleged perpetrator still works with or cares for children and young people.

## 4.13 About domestic violence (section 23 d)

Domestic violence is violent, abusive or intimidating behaviour carried out by an adult against a partner or former partner to control and dominate that person. It is most often violent, abusive or intimidating behaviour by a man against a woman. Domestic violence has a profound effect on children and young people and constitutes a form of abuse.

Some of the forms of domestic violence are physical assault, sexual assault, emotional abuse, social abuse (being isolated socially or geographically against one's will) and economic abuse (having restricted or limited access to or control over money and other resources).

Serious psychological harm involves the impairment of, disturbance or damage to a child or young person's physical, cognitive, emotional, behavioural or social development. There are varied manifestations of psychological harm which are affected by age, personality, length of exposure to incidents of domestic violence, nature of the incidents, and any remedial assistance given to the child or young person and their family for dealing with or ameliorating the harm.

Children and young people may experience harm from domestic violence on a number of levels. They may be:

- direct victims of physical and emotional abuse
- indirect victims when attempting to protect another person
- victims of emotional and psychological trauma by living in a climate of fear and intimidation as a result of domestic violence in the household.

Serious psychological harm should be assumed in the presence of any of the following factors:

- the repetition or an escalation in frequency or severity of violence in the household
- whether a child or young person has been physically harmed
- if the victim has required medical attention as a result of the violence
- where weapons have been used
- apprehended violence orders have been issued and/or breached
- threats to take or harm children.

Serious psychological harm may also arise in circumstances where:

- the parent or caregiver is unable to protect the safety, welfare or well-being of the child or young person due to the level of victimisation
- domestic violence exists with one or more factors such as the hazardous use of alcohol or other drugs
- there are other factors that may increase the vulnerability of the child or young person such as the presence of a mental health problem or a disability.

#### **4.14 About psychological harm or emotional abuse (section 23e)**

Emotional abuse covers a range of behaviours that may cause psychological harm to a child or young person. It is behaviour by a parent, caregiver, older child or other person that can damage the confidence and self-esteem of a child or young person resulting in serious emotional deprivation or trauma. Emotional abuse is also experienced by a child or young person when living in a situation of domestic violence.

Serious psychological harm involves the impairment of, disturbance or damage to a child or young person's cognitive, emotional, behavioural or social development.

For more information on 'The Impact and Dynamics of Child Abuse and Neglect' please see Appendix 6.

# 5

## Recognising child abuse and neglect - indicators

There are many indicators of child abuse and neglect. The indicators on pages 15 – 18 are from the Interagency Guidelines on Child Protection Intervention 2000 and are a guide to help Health workers recognise child abuse and neglect. It is not a comprehensive list of all harms, behaviours or presentations that give rise to concerns or suspicions of child abuse or neglect. One indicator in isolation may not necessarily indicate abuse or neglect and each indicator needs to be considered in the context of the child or young person's personal circumstances.

It is important that these indicators are not seen as a list of the grounds for making a report to the Department of Community Services.

The list includes contextual indicators that relate to all types of abuse and neglect. These are useful when you have to consider the likelihood that an injury, behaviour or disclosure of a child or young person is related to or caused by abuse or neglect.

The indicators are grouped by type – physical, sexual and emotional abuse and neglect. They are described in terms of a child or young person's presentation and the behaviours of those who abuse and neglect children and young people.

Some questions that may help you decide whether you have grounds to believe a child or young person is at risk of harm from child abuse and neglect include:

- Neglect:
- Are the child or young person's basic physical needs not being met or at risk of not being met ?
  - Are the child or young person's basic psychological needs not being met or at risk of not being met?

Medical care: Does the child or young person require necessary medical care?

Have the parents failed to arrange for necessary medical care or are they unable or unwilling to do so?

Are the child or young person's basic physical needs at risk of not being met?

Physical abuse: Is the child or young person being physically abused or ill treated?

Are they at risk of being physically abused or ill treated?

Sexual abuse: Has the child or young person been sexually assaulted or ill treated?

Are they at risk of being sexually assaulted or ill treated?

Domestic violence: Does the child or young person live in a household where there is domestic violence?

As a result, are they at risk of suffering serious physical or psychological harm?

Emotional abuse: Have the child or young person's parents or caregivers behaved in such a way towards them that the child or young person has suffered serious psychological harm?

Is the child or young person at risk of suffering serious psychological harm?

## Indicators Of Abuse And Neglect

**One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances. The lists are not in hierarchical order.**

### Setting the context

**The following factors in the life circumstances of the child or young person are relevant when considering indicators of abuse and neglect.**

- history of previous harm to the child or young person
- social or geographic isolation of the child, young person or family, including lack of access to extended family or supports
- abuse or neglect of a sibling
- family history of violence including injury to children and young people
- domestic or dating violence

### Physical or mental health issues for the parent or carer affecting their ability to care for the child or young person

- the parent or carers' abuse of alcohol or other drugs affecting their ability to care for the child or young person
- a deficiency in functional parenting skills required to provide for the safety, welfare and well-being of children and young people
- the parent or carer is experiencing significant problems in managing the child's behaviour
- the parent or carer has unrealistic expectations of age appropriate behaviour in the child or young person
- the parent is experiencing significant problems in relating to the young person

### General indicators of abuse or neglect in children and young people

- where the child or young person gives some indication that the injury or event did not occur as stated by the parent, carer or other adult
- where the child or young person tells you she/he has been abused

- when the child or young person tells you she/he knows someone who has been abused, may be referring to herself/himself
- someone else tells you such as a relative, friend, acquaintance or sibling of the child or young person that the child or young person may have been abused
- poor concentration
- sleeping problems eg. nightmares, bed wetting
- marked changes in behaviour or mood, an escalation in risk-taking behaviours, tantrums, aggressiveness, withdrawal
- child or young person complains of stomach aches and headaches with no physical findings
- unrealistic expectations of a young person including failure to allow the young person to participate in decisions that affect them or expecting adult behaviours

### General indicators of abuse or neglect in young people

- self harming behaviour such as cutting or burning self
- high level of risk taking behaviours such as climbing up cliff faces while intoxicated.
- substance abuse
- involvement in criminal activities such as stealing and fighting
- social isolation
- difficulty in maintaining long term peer relationships
- persistently negative themes in art work and creative writing
- homelessness

## Indicators of neglect

### Indicators in children and young people

- poor standards of hygiene leading to social isolation
- scavenging or stealing food
- extended stays at school, public places, others' homes
- being focused on basic survival
- extreme longing for adult affection
- flat and superficial way of relating, lacking a sense of genuine interaction
- anxiety about being dropped or abandoned
- self comforting behaviour, eg. rocking, sucking
- non-organic failure to thrive
- delay in developmental milestones
- loss of 'skin bloom'
- poor hair texture
- untreated physical problems

### Indicators in young people

- staying at the homes of friends and acquaintances for prolonged periods, rather than at home
- resources are not provided, which would allow the young person to care adequately for himself or herself, eg access to washing or food

### Indicators in parents or carers

- failure to provide adequate food, shelter, clothing, medical attention, hygienic home conditions or leaving the child or young person inappropriately without supervision
- inability to respond emotionally to a child or young person
- leaving a child or young person alone for long periods
- depriving of or withholding physical contact or stimulation for prolonged periods
- failure to provide psychological nurturing
- treating one child or young person differently, for example scapegoated
- absence of social support from relatives, other adults or social networks

## Indicators of physical abuse or ill treatment

### Indicators in children and young people

- facial, head and neck bruising
- lacerations and welts from excessive discipline or physical restraint
- explanation offered by the child or young person is not consistent with the injury
- other bruising and marks which may show the shape of the object that caused it (eg. a hand-print, buckle)
- bite marks and scratches where the bruise may show a print of teeth and experts can determine whether or not it is an adult bite
- multiple injuries or bruises
- ingestion of poisonous substances, alcohol, drugs or major trauma
- dislocations, sprains, twisting
- fractures of bones, especially in children under 3 years
- burns and scalds
- head injuries where the child or young person may have indicators of drowsiness, vomiting, fits or retinal haemorrhages suggesting the possibility of the child having been shaken

### General indicators of female genital mutilation (FGM)

- having a special operation associated with celebrations
- reluctance to be involved in sport or other physical activities when previously interested
- difficulties with toileting or menstruation
- anxiety about forthcoming school holidays or trip to country which practises FGM
- older siblings worried about their sisters visiting their country of origin
- long periods of sickness

### **Indicators in young people**

- aggressive or violent behaviour towards others, particularly younger children
- explosive temper that is out of proportion to precipitating event
- being constantly on guard around adults and cowering at sudden movements

### **Indicators in parents or carers**

- direct admissions by parents or carers that they fear they may injure the child or young person
- family history of violence, including previous harm to children and young people
- history of their own maltreatment as a child or young person
- repeated presentations by the parent of the child or young person to health or other services with injuries, ingestions or with minor complaints
- marked delay between injury and the parents' presenting the child for medical assistance
- parental accounts of injury which are inconsistent with the physical findings
- parental accounts of injury which are vague, bizarre or variable

### **Indicators of behaviour causing psychological harm**

#### **Indicators in children and young people**

- feelings of worthlessness about life and themselves
- inability to value others
- lack of trust in people and expectations
- lack of interpersonal skills necessary for adequate functioning
- extreme attention seeking or risk taking behaviour
- other behavioural disorders (eg. disruptiveness, aggressiveness, bullying)

### **Indicators in young people**

- avoiding all adults
- being obsessively obsequious to adults
- difficulty in maintaining long term significant relationships
- being highly self critical

Children and young people sustain psychological harm from all the types of abuse.

### **Indicators in parents or caregivers**

- constant criticism, belittling, teasing of a child or young person, or ignoring or withholding praise and affection
- excessive or unreasonable demands
- persistent hostility and severe verbal abuse, rejection and scapegoating
- belief that a particular child or young person is bad or 'evil'
- using inappropriate physical or social isolation as punishment
- situations where an adult's behaviour harms a child's or young person's safety, welfare and well-being
- exposure to domestic violence

### **Indicators of sexual abuse or ill treatment**

#### **Indicators in children and young people**

- describe sexual acts (eg. 'Daddy hurts my wee-wee')
- direct or indirect disclosures
- age inappropriate behaviour and/or persistent sexual behaviour
- self-destructive behaviour, drug dependence, suicide attempts, self-mutilation
- persistent running away from home
- eating disorders
- going to bed fully clothed
- regression in developmental achievements in younger children
- child or young person being in contact with a known or suspected perpetrator of sexual assault
- unexplained accumulation of money and gifts

- bleeding from the vagina or external genitalia or anus
- injuries such as tears or bruising to the genitalia, anus or perineal region
- sexually transmitted diseases
- adolescent pregnancy
- trauma to the breasts, buttocks, lower abdomen or thighs

### **Indicators in young people**

- particularly negative reaction to adults of only one sex
- sexually provocative
- desexualisation, eg wearing baggy clothes in order to disguise gender. Eating disorders may be a possible indicator in this category
- art work or creative writing with obsessively sexual themes
- preoccupation with causing harm to men they suspect are homosexual
- engaging in violent sexual acts which they talk about
- knowledge about practices and locations which are usually associated with prostitution

### **General indicators of stress in a child or young person**

- poor concentration at school
- sleeping/bedtime problems eg. nightmares, bed wetting
- marked changes in behaviour or mood, tantrums, aggressiveness, withdrawal
- child complains of stomach aches and headaches with no physical findings

### **Indicators in parents, caregivers, siblings, relatives, acquaintances or strangers**

- exposing a child or young person to prostitution or child pornography or using a child or young person for pornographic purposes
- intentional exposure of child or young person to sexual behaviour in others
- ever committed/been suspected of child sexual abuse
- inappropriate curtailing or jealousy regarding age-appropriate development of independence from the family
- coercing child or young person to engage in sexual behaviour with other children and young people
- verbal threats of sexual abuse
- denial of adolescent's pregnancy by family
- perpetration of spouse abuse or physical child abuse

Offenders use a range of tactics including force, threats, and tricks to engage children or young people in sexual contact and to try to silence the child or young person. They may also try to gain the trust and friendship of parents in order to obtain access to children and young people.

Reproduced from the Interagency Guidelines for Child Protection Intervention 2000

# Becoming aware of risk of harm of abuse



## 6.1 If a child tells you about abuse

If a child or young person tells you about abuse, record the time and date you spoke with them and, as far as possible, their exact words. Children and young people should not be asked to give details about the abuse. This is the role of the Department of Community Services or the Police. The role of Health workers is to assess if a report should be made to the Department of Community Services, not to investigate information. The investigation of risk of harm of abuse is the role of the Department of Community Services or the Police.

As the child or young person talks to you:

- react calmly to the information they provide
- listen actively and be non-judgemental
- don't ask leading questions eg did he touch your vagina?
- reassure them that they have done the right thing to tell and that it is not their fault
- let the child or young person know that they are not alone and you know that this has happened to many children and young people
- don't make promises that you can't keep, particularly around not telling anyone else about this information
- if it is appropriate and will not place the child or young person at risk, tell them about your obligation to report
- if appropriate, reassure and support the caregivers present.

## 6.2 If you become aware of abuse when working with an adult

Health workers may become concerned that a child is at risk of harm in many ways other than the direct disclosure by a child or young person. These situations may include:

- an adult client disclosing abuse of a child or young person
- the parent or caregiver of a child or young person disclosing abuse of their child
- a Health worker working with an adult client who is a caregiver forming the view that the adult is not capable of caring for their children at that time due, for example, to physical or mental health problems or disorders, intoxication or distress
- a Health worker working with a pregnant woman forming the view that the woman may not be able to care for her child when born, and a report made on the basis of supportive intervention may reduce the likelihood of her baby being placed in out-of-home care.

Health workers are not required to actually see a child or young person before making a report to the Department of Community Services.

## 6.3 Evidence of first complaint

If you are the first person the child or young person tells about abuse that constitutes a crime, you may be called to court to give evidence. This is called evidence of first complaint. It is therefore important that the information you receive from the child or young person is recorded accurately in their Health record.

## 6.4 Safety issues

### 6.4.1 Disclosure of child sexual assault

Disclosure of child sexual abuse is a crisis situation. The Health worker to whom the disclosure is made must not confront the alleged perpetrator as this may lead to further risk to the child. Approaching the alleged perpetrator is the role of the Department of Community Services or the Police.

If a child discloses and the alleged perpetrator is at the premises of the Health service or due to pick up the child, relay the immediacy of need for intervention to the Department of Community Services and, if possible, keep the child separate from the alleged perpetrator. If the Department of Community Services officer is not expected to arrive for some time and it would be difficult to keep the child separate from the alleged perpetrator, you should ask the Department of Community Services officer for advice about how to handle the situation. If there are concerns about the immediate safety of the child or a worker, contact the Police or Security staff.

#### **6.4.2 Disclosure or suspicion of physical or emotional abuse or neglect (PANOC)**

In many cases of PANOC, the suspicion is generated at the time the Health worker is in contact with the child or young person. Once these suspicions are present, you may need to ask the family members accompanying the child further questions to clarify the consistency of the history given. Once you form the view that the child or young person is at risk of harm, you must make a report immediately to the Department of Community Services.

#### **6.4.3 Informing children, young people and families of a report**

It is good practice to highlight the constraints of confidentiality at the first contact with all children and their families as part of any explanation of the service that may be provided. It is also useful to engage children and families in making decisions, as appropriate and safe, should the need to report risk of harm to children arise, as children and families who participate in decisions about their lives are more likely to support the decisions made. This will enable the child or family to be involved in the process of making a report and will assist in making the process of reporting transparent. It is often helpful to assume that clients may wish to participate more actively in resolving difficulties that place their children at risk. However if the worker assesses that informing the child, young person or their family may potentially place them or the worker at risk, they should not be informed.

Other family members who are not present when the concerns arise should not usually be approached about the need to make a report, particularly in the case of suspected domestic violence or sexual assault.

The dynamics of sexual assault and domestic violence in particular mean that it is important not to inform the alleged offender that a report will be made, as they may pressure the child or young person to retract their disclosure. The non-offending caregiver should also not be informed except where they have provided the information and the Health worker assesses it to be safe. Health workers who are unsure should consult their Supervisor/Manager before informing a child, young person or parent/caregiver of the decision to report.

#### **6.4.4 Worker safety**

If a Health worker is threatened with or fears personal violence as a result of, for example, making a report to the Department of Community Services then the threat should be reported to the Police. The Police may apply for, and pursue on the Health worker's behalf, an apprehended violence order (AVO). Individuals may also obtain an AVO by making an application to a Chamber Magistrate at a Local Court. You could also consult the designated Occupational Health and Safety officer in your Area Health Service.

It is good practice for Health workers to inform their supervisor or manager when they are working with children or young people at risk. Child protection issues are complex and may raise both professional and personal issues for Health workers. Informing your supervisor or manager of child protection cases as they arise, helps them to be aware that you may need additional support or supervision. You may also contact your Area Health service for information about contacting the Area Staff Counsellor or Employee Assistance Program (EAP).

## 6.5 Special Needs Groups

### 6.5.1 Using interpreters

Principles of social justice require that non-English speaking people have access to the same high quality health services enjoyed by the rest of the population. NSW Health policy (Circular 94/10) supports the use and availability of professional interpreters.

Unqualified or non-accredited interpreters often make poor communicators in critical health situations. Using family members or friends as interpreters may place the child or young person's safety at risk and should not be NSW Health practice. Communication problems involving clients with limited English can also carry legal risk for health service staff.

Interpreters must convey all the information received from the client to the Health worker before, during, and after the end of the interpreting session.

If support services are discussed with a non-English speaking client, they should be consulted about their preference for involvement of ethnic specific agencies or the use of mainstream services.

### 6.5.2 Indigenous communities

It is a principle of the Children and Young Persons (Care and Protection) Act 1998 that Aboriginal and Torres Strait Islander people are to participate in the care and protection of their children and young people with as much self-determination as possible. This principle recognises the profound and ongoing effect on Aboriginal communities of the stolen generation of Aboriginal children and takes into account that child removal is a particularly sensitive matter for Aboriginal people.

If the presenting child or family is from an Aboriginal or Torres Strait Islander background, Health workers should make sure that the family is asked if they would like either an Aboriginal Liaison Officer, Education Officer or Health Coordinator to be contacted.

You need to be sensitive when working with Aboriginal and Torres Strait Islander families, particularly if there may be concerns about risk of harm that need to be reported to the Department of Community Services. It is good practice to be transparent about your concerns where this is appropriate and safe.

### 6.5.3 Clients with disabilities

If a child or parent has a disability, you must consider how to appropriately facilitate communication eg by using signing interpreters. Clients with disabilities should be offered the opportunity to request a support person or advocate or consult a disability or other advocacy service.

# 7

## Health workers responsibilities to report

In addition to being aware of the rights of children and young people and their parents, Health workers need to clearly understand their own legal obligations and responsibilities towards children, young people and their caregivers.

### 7.1 Legal obligations in relation to children under the age of 16

Under section 27 of the Children and Young Persons (Care and Protection) Act, a person who:

- in the course of his or her professional work or other paid employment delivers health care to children, and
- has reasonable grounds to suspect that a child is at risk of harm

must, as soon as practicable, report to the Department of Community Services the name, or a description, of the child and the grounds for suspecting that they are at risk of harm.

Similarly, under section 27 of the Act, a person who:

- holds a management position in an organisation the duties of which include direct responsibility for, or supervision of, the provision of health care wholly or partly to children, and
- has reasonable grounds to suspect that a child is at risk of harm

must, as soon as practicable, report to the Department of Community Services the name, or a description, of the child and the grounds for suspecting that they are at risk of harm.

Health workers who fail to comply with this legal obligation may be guilty of an offence. The maximum penalty for a person found guilty of this offence is 200 penalty units (currently \$22,000).

In addition to this legal requirements under Ministerial directive all Health workers who have reasonable grounds to suspect that a child is at risk of harm, irrespective of whether the Health worker is delivering a service to the child, must make a report to the Department of Community Services. Health workers who fail to comply with a Ministerial directive may be subject to disciplinary action.

Health workers who provide services to adults have an obligation to consider the parenting capacity of the adult clients in meeting their obligations to assess and report risk of harm.

### 7.2 Legal obligations in relation to young people aged 16 and 17 years

Under section 24 of the Act, a Health worker may report concerns about risk of harm relating to a young person aged 16 or 17 years.

If you are concerned that a young person is at risk of harm from abuse or neglect, you should make a report. The young person should be involved in the decision to report and the process of reporting, unless there are exceptional reasons for excluding them. If the young person does not agree to the report being made, this information must be conveyed to the Department of Community Services as they must consider the young person's wishes in any investigations and assessments.

### **7.3 Legal obligations in relation to children and young people who are homeless**

Under section 120 of the Act, a person may report homelessness of a child to the Department of Community Services.

Under section 121 of the Act, any person may report the homelessness of a young person, with the consent of the young person.

### **7.4 Legal obligations in relation to a class of children or young people**

If there are reasonable grounds to suspect risk of harm related to the abuse of a class of children or young people, a report may be made in accordance with section 24 of the Act. Examples of a 'class' of children or young people include more than one child or young person in a community group, more than one child in a child care centre or more than one child or young person in a school.

### **7.5 Legal obligations in relation to pre-natal reports**

Under section 25 of the Act, a Health worker who has reasonable grounds to suspect, before the birth of a child, that a child may be at risk of harm after his or her birth may make a report to the Department of Community Services. The intention of this report process is supportive intervention rather than interference in the rights of the pregnant woman.

Pre-natal reporting may be helpful for pregnant women in domestic violence situations, with a mental health problem, or who use hazardous drugs during pregnancy because reporting can be a catalyst for assistance. However, pre-natal reporting should only be used where there are clear indications that the infant may be at risk of harm after they are born.

### **7.6 Protection for Health workers who report**

Under section 29 of the Act, protection is afforded to a Health worker making a report. In accordance with sections 29 and 258 of the Act, if a report is made in good faith, or information is furnished in relation to the safety, welfare and well-being of a

child or young person or class of children or young people, the reporting or provision of information:

- does not constitute a breach of professional etiquette or ethics or a departure from acceptable standards of professional conduct
- does not constitute grounds for liability for defamation
- does not constitute grounds for civil proceedings for malicious prosecution or conspiracy
- cannot be admitted in evidence against a person in any court proceedings.

A person cannot be compelled in any proceedings to produce a report or a copy of or extract from a report, or to disclose or give evidence of any of its contents. The identity of a person who made a report cannot be disclosed except where the person gives consent, or with the leave of the court or other body where proceedings relating to the report are conducted.

In addition, if a report of suspected risk of harm is made to the DoCS Helpline in good faith, grievance proceedings cannot be initiated or allowed to progress against the person making the report in relation to that person's report. Area Health Service Chief Executive Officers are responsible for ensuring that existing grievance proceedings recognise this.

### **7.7 Situations where a Health worker forms an opinion not to report**

If you identify possible indicators that there is a potential for a child or young person to be at risk of harm, but assess in consultation with your supervisor or manager that a report is not required at that time because there are not sufficient grounds to form a reasonable suspicion, you must consider what additional support services should be put in place to further support the child, young person or family. This may include facilitating referrals to a Youth Health Service, Family Support Service or Early Childhood Service.

Health worker must always clearly document these decisions. For more information about documenting this process, please see chapter 10.4.

## **7.8 What should a Health worker do if they are uncertain about making a report?**

Child protection concerns are complex and there will be situations where you may be unclear if a report is required. In these situations, you should discuss the child protection concerns with your supervisor or manager, where available and appropriate. Alternatively, each Area Health Service has PANOC and Sexual Assault Services who are available for consultation about physical or emotional abuse and neglect or sexual assault services.

## **7.9 Consultation with the Department of Community Services**

The Department of Community Services Helpline 13 36 27 is also available for Health workers to consult about reporting risk of harm.

## **7.10 What if there is disagreement about whether to make a report?**

Anyone, regardless of professional status, has the legal right to report risk of harm to the Department of Community Services whether or not this view is held by all the Health workers involved with the case. If there is a disagreement about risk of harm, the individual worker who has reasonable grounds to suspect that a child is at risk of harm should still make a report to the Department of Community Services. This report will be covered by the provisions of the Act.

If children are not reported, their safety needs cannot be properly assessed and they may be left vulnerable to further abuse or neglect. The Department of Community Services is the statutory body in NSW with the power to investigate the protective needs of children.

## **7.11 Offences under the Children and Young Persons (Care and Protection) Act**

Certain activities are offences under the Act. There is no legal obligation on Health workers to report these offences to the Department of Community Services unless a child or young person is considered to be at risk of harm. The following offences all have maximum penalties of 200 penalty units, currently \$22,000.

### **Abuse and neglect**

Under sections 227 and 228 of the Act, it is an offence to abuse or to neglect a child or young person.

### **Unauthorised removal of children from Hospitals or other premises**

Under section 229 of the Act, it is an offence to remove or cause to remove a child or young person from a person into whose care that child or young person has been placed under the Act. It is also an offence for a person who is in charge of any hospital or other premises where a woman gives birth to permit a child not in the charge of the child's mother to be taken from the premises without the consent of the Department of Community Services.

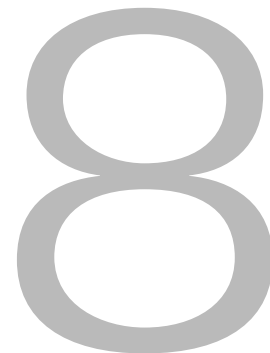
### **Tattooing**

Under section 230 of the Act, it is an offence to tattoo any part of the body of a child or young person without the prior written consent of their parent.

### **Unsupervised children in motor vehicles**

Under section 231 of the Act, it is an offence to leave any child or young person unsupervised in a motor vehicle in circumstances where the child or young person becomes or is likely to become distressed, or where the child or young person's health becomes or is likely to become permanently or temporarily impaired.

# Making a report



## 8.1 How to make a report to the Department of Community Services (DoCS) Helpline

A Health worker who has reasonable grounds to suspect that a child or young person is at risk of harm should make a report by phoning the DoCS Helpline on 13 36 27.

You should identify yourself by name, position and Area Health Service to the DoCS Helpline officer.

You should then either:

- Fill out the form for reporting to the Department of Community Services and place this on the client's Health record, or
- Document the report, as outlined in chapter 10.3, in the client's Health record on a separate page under the heading 'Report to the Department of Community Services'. This will make it easy to identify the information and remove it, if necessary, from the file.

It is critical that documentation of the report includes the call reference number allocated by the DoCS Helpline. Any additional local procedures for recording reports to the Department of Community Services should be followed.

The DoCS Helpline operates 24 hours a day, 7 days per week. When the Helpline receives a report, they are required by law to make an assessment and decide whether the child or young person is actually at risk of harm.

## 8.2 Information that the Department of Community Services may require

The DoCS Helpline officer may ask a range of questions to help them make a decision about the level of harm at which the child or young person is at risk. This information may include:

- the name or description of the child or young person, or class of children or young people
- the current whereabouts of the child or young person
- whether risk of harm is related to a staff member of an organisation
- when the child was last seen
- the name and address, if known, of the person suspected of abusing the child or young person and, if possible, their occupation
- whether a language or sign interpreter may be needed, or support required for a person with a disability, or an Aboriginal agency should be involved
- all available information relating to the safety, welfare and well-being of the child or young person
- the reasons for concern about risk of harm
- the child or young person's views about the report, if known
- events, conversations and observations that lead to concern – these should be recorded and available for reference
- information about the child or young person's history, current circumstances and their views
- information about the parent, family or caregivers
- information about relationships
- information about the agency's role and relationship with the child, young person and their family.

### 8.3 Police involvement

The Department of Community Services has no power under the Act to lay charges where a criminal offence may have been committed. Therefore all reports which involve a criminal offence under the Crimes Act 1900 must be referred by the Department of Community Services to the Police. This includes, for example, if:

- the child has died
- the child has received a life threatening or serious injury
- the child has been physically or sexually assaulted
- there is torture involved
- removal of the perpetrator is necessary to protect the child
- a person has neglected to a serious degree to provide adequate food, nursing, medical treatment, clothing, material aid or lodging for a child.

If a child is critically ill or injured and may die, the Health worker should immediately notify the Department of Community Services. The Department of Community Services should also be informed if there are immediate safety concerns about a child or young person. The Department of Community Services is required to notify the Police of all cases of child sexual assault.

### 8.4 Parents removing or discharging children or young people against medical advice

If parents remove their child from a hospital against medical advice, the hospital staff may report the matter to the Department of Community Services under section 27 if they have reasonable grounds to suspect the child is at risk of harm to the child. The Department of Community Services will then assess the information reported by the hospital staff and may visit the family at home, make an assessment and may return the child to hospital. The Department of Community Services will liaise with the Police if necessary.

Health workers have no legal authority to detain a child. The Department of Community Services does however, have the statutory authority to assume care and protection of a child or young person in hospital or any other premises under an order issued pursuant to section 44 of the Children and Young Persons (Care and Protection) Act 1998. This order is made in writing and is served on the person who appears to be in charge of the hospital premises or unit, such as the Nursing Unit Manager. Orders signed by the Director-General of the Department of Community Services may include an emergency care and protection order, an examination and assessment order or any other care order. A copy of the order made must be placed in the client's Health record. For more information on these orders, please see Chapter 14.

Please refer to chapter 15 for more information on medical treatment and examinations.

### 8.5 Feedback to Health workers making a report

The Department of Community Services is responsible for providing feedback to a person making a report. Any person making a report will be advised in writing of what action has been taken. You can contact the DoCS Helpline on 13 36 27 for information about what action has occurred after 24 hours or after an initial assessment has been made. If the case has been referred to a Department of Community Services Community Services Centre, you can phone the local office for information about what follow-up has occurred.

### 8.6 Brief guide to making a report

There is an abridged version of this section in Appendix 1 which you can use as a ready reckoner to making a report to the Department of Community Services.

### 8.7 Interagency guide to making a report to DoCS

The Department of Community Services has developed a 'Guide to Making a Report' to help workers from other agencies decide whether to report a child or young person at risk of harm. There is a copy of this guide in Appendix 4.

# Information provision



## 9.1 Responsibility to provide information to the Department of Community Services

Under section 248 of the Act, Health Services may be required to provide information to the Department of Community Services (DoCS). It is a legal obligation to comply with a request for information made under section 248. Maintaining the confidentiality of a client is not a sufficient reason for failing to respond to a section 248 Request For Information.

The key factors of this provision are:

- The request must be made using the Department of Community Services 'Information Request' form.
- The information requested can only be information relating to the safety, welfare and well-being of a particular child or young person or a class of children or young people.
- The request cannot require Health Services to collect or obtain new information. The request only applies to information already held by the Health Service.

The Department of Community Services may request information about:

- the child or young person's history, current circumstances and their views
- the parent or family
- other relationships
- the agency's role and relationship with the child, young person and family
- the capacity of the parent to adequately care for the child which could include information on domestic violence, drug and alcohol or mental health concerns.

When making a request for information under section 248, the Department of Community Services will clearly outline:

- the subject of the information request and, if this is an adult, their relationship to the child or young person
- how the request for information relates to safety, welfare and well-being and risk of harm issues
- identifying information so Health workers can check they are talking about the appropriate person
- the timeframe for providing the information.

## 9.2 Agreed timeframes for responding to section 248 requests

NSW Health and the Department of Community Services have agreed the following timeframes for responding to section 248 requests for information. It is important that all staff comply with these timeframes when responding to requests for information.

## 9.3 After hours and weekend requests

Health Services may receive section 248 requests for information after business hours and on weekends. You are only required to provide information on whether a nominated person has attended a hospital or after hours crisis service.

Area Health Services should make reasonable efforts to respond to after hours and weekend requests for information. The information that you can be reasonably expected to provide includes whether a client has made contact with a Health service, the name of the service, the last date of contact and nature of the contact.

## 9.4 Urgent requests

If the identity of the Health service that has had contact with a child, young person or other person nominated on the section 248 request is known, Area Health Services should make efforts to respond to the Department of Community Services as soon as practicable within 24 hours. Information that can reasonably be expected to be supplied within this timeframe includes whether the client has made contact with a Health service, the name of the service, the last date of contact with the client and the nature of the contact.

If the identity of the Health service is not known, Area Health Services should make reasonable efforts to establish whether the nominated person has had contact with any Health service in its boundaries. If it is established that the nominated person has had contact with a Health service, you should supply the Department of Community Services within 72 hours with the name of the service, the last date of contact with the client and the nature of the contact.

## 9.5 Standard requests

Area Health Services should make efforts to provide the Department of Community Services with the requested information within 5-10 days.

## 9.6 Requests for written reports

Area Health Services must provide the Department of Community Services with the requested information within 3 weeks. This timeframe relates to reports requested under section 248 only.

## 9.7 Establishment of a central contact point and register for responding to section 248 requests for information

NSW Health and the Department of Community Services have agreed that all section 248 requests for information will be directed to a single central contact point in an Area Health Service using the Department of Community Services 'Information Request' form.

If frontline Health workers receive requests for information directly, they must immediately inform and consult with their service manager and the central contact point with their Area Health Service.

Each Area Health Service must establish a central contact point to which requests can be directed and from which responses to the Department of Community Services will be sent.

Procedures will need to be put in place to allow the appropriate Health service manager to compile the information provided by the Health service and send the response to the Department of Community Services.

All responses to section 248 requests should be made using the 'Response to an Information Request' form. There is a copy of this form in Appendix 5.

Details of the requests and a note as to what information was provided must be recorded in the Health record from which the information was taken.

## 9.8 Responding to urgent requests for information

In urgent situations, an Area Health Service may provide information to the Department of Community Services by telephone. This information should then be confirmed in writing through the central contact point using the 'Response to an Information Request' form.

## 9.9 Uncertainty about whether to provide information

Staff with expertise in child protection should be consulted about requests where there is a dispute or uncertainty as to what information should be provided to the Department of Community Services.

## **9.10 Health workers requesting information from the Department of Community Services**

Section 248 also allows the Department of Community Services to provide information to other agencies including Health services. The Department of Community Services is not however obliged to respond to requests from other agencies and will only provide information if they have assessed that it is appropriate in the circumstances. Health workers should use the agency 'Information Request' form in Appendix 5 of this manual when requesting information from the Department of Community Services.

## **9.11 Information requested by the Child Death Review Team**

Under the Children and Young Persons (Care and Protection) Act 1998, the Child Death Review Team can request full and unrestricted access to NSW Health records. Please read NSW Health Circular 96/73 for information about how Area Health Services should respond to requests for information from the Child Death Review Team.

## **9.12 Protection under legislation for Health workers**

Health workers providing information to the Department of Community Services under section 248 are protected by the Children and Young Persons (Care and Protection) Act 1998. Providing this information to the Department of Community Services is not a breach of professional ethics or standards of professional conduct and does not carry liability for defamation or constitute grounds for civil action.

# 10 Documenting relevant information

Health records provide documented evidence of a child's health, illness, injuries and management for each visit or stay in a health facility. All clinical findings must be recorded in an accurate and objective manner. Reports must be up-to-date and include a full disclosure of all the facts. Health records can be used as evidence in court.

Health records must be kept confidential, current, complete and readily available for patient care.

## 10.1 Documentation about physical and emotional abuse and neglect of children and young people

You must make sure that all information is accurately recorded, including:

- time of presentation
- languages spoken and need for interpreter
- physical injury, size, colour, shape of markings, type etc - use body maps
- history given by child in the course of a medical examination
- clinical observations and whether these are consistent with the history given by the child and family
- social, emotional, developmental and nutritional assessment of child and family
- all treatment given, for example drugs prescribed, referral for x-ray, admission and reason, blood tests
- growth percentiles.

## 10.2 Documentation about child sexual assault

All relevant medical information is recorded on the Child Sexual Assault Medical Protocol by appropriate medical practitioners and in the Health records and file notes by other staff members.

The Child Sexual Assault Medical Protocol is used for children up to 14 years old and the Adult Sexual Assault Medical Protocol is used for young people aged 14-16 and over.

## 10.3 Documenting a report made to the Department of Community Services

If you made the report to Department of Community Services (DoCS), you must record the following information in the client's Health record.

- the time and date the report was made
- the name of the caseworker you spoke to at the DoCS Helpline
- the information given to DoCS
- DoCS response to the report, if known
- the call reference number allocated by the DoCS Helpline.

This information may be attached to the client's health record file using the form in Appendix 5. Written feedback from DoCS to the reporter should also be attached to the client's Health records.

## 10.4 Documenting situations where consideration is given to making a report

Health workers must document all information relating to child protection concerns in the child or young person's Health record.

If you have considered the possibility of risk to a child but have decided that you do not have reasonable grounds to suspect a child is at risk of harm and therefore make a report to DoCS, you should document:

- the identified risk factors for the child or young person
- the identified preventative factors that mitigate against risk of harm
- whether the DoCS Helpline was consulted, and if so the time and date and the name of the Helpline officer you spoke to, if known
- any supports put in place for the child, young person and their family
- the name of the supervisor or manager consulted, if appropriate.

## 10.5 Requests for written reports

If you receive a request for a report from DoCS or the courts, you must document in the client's Health record the source of the request, the means of receiving the request, and the original request. A copy of the report given to the Department of Community Services or to the court must also be placed in the client's Health record.

You must inform your supervisor or manager that you are providing a report to DoCS. For more information about the procedures for reports requested under section 248 of the Act, please see Chapters 9 and 10.

If a written report is provided as a result of a section 173 medical examination order, the names of the children to be examined, and any reasons given by the parents for not agreeing to the notice requiring a medical examination, should be included. NSW Health does not charge for providing reports requested by the Department of Community Services.

## 10.6 Documentation of section 248 exchange of information requests

If section 248 requests for information are received from the Department of Community Services, the request and a note as to what information was provided should be recorded in the Health record from which the information was taken.

## 10.7 Access to health records by children, young people and their families

There are special provisions to protect the confidentiality of clients if records are subpoenaed during child sexual assault counselling. For more information, please refer to NSW Health Circular 99/18 and the NSW Health Privacy Code of Conduct about client access to sensitive records, NSW Health Circular 98/29 about subpoenas, and to the Criminal Procedure Act 1986 and the Evidence Act 1997.

# 11

## Best endeavours requests for service

### 11.1 What are best endeavours requests for service?

Under section 17 of the Children and Young Persons (Care and Protection) Act 1998, the Director-General of the Department of Community Services may request services from other agencies.

S.17. In deciding what action should be taken to promote and safeguard the safety, welfare and well-being of a child or young person, the Director-General may request a government department or agency, or a non-government agency in receipt of government funding, to provide services to the child or young person or to his or her family.

Agencies have a legislative obligation to cooperate with the Department of Community Services when it makes a request for assistance under section 17. The Act states that:

S. 18. The government department or agency must use its best endeavours to comply with the request made to it under S.17 if it is consistent with its own responsibilities and does not unduly prejudice the discharge of its functions.

In addition, under section 85 of the Act, the Children's Court may make requests which also require agencies to use the same standard to respond.

S. 85 A government department or agency or a funded non-government agency that is requested by the Children's Court to provide services to a child or young person or his or her family in order to facilitate restoration is to use its best endeavours to provide those services.

### 11.2 Interagency agreements for best endeavours requests

The *Interagency Guidelines for Child Protection Intervention 2000* provide some agreed parameters for making and responding to section 17 best endeavours requests.

*'Best endeavours' means to exercise a genuine and considered effort to respond to a request for services to promote and safeguard the safety, welfare and well-being of the child or young person.*

*Requests may involve clients who in the first instance do not attend, or who appear reluctant to attend services. In such cases 'best endeavours' would include practitioners making efforts to follow up the person referred and encourage their attendance.*

In using best endeavours government agencies should:

- have documented intake procedures for children, young people and families that prioritise those who are vulnerable
- consider risk of harm issues in prioritising the request for a service
- manage services flexibly to deal with high demand so that children or young people's safety, welfare or well-being is not compromised
- deliver accessible services
- use active attempts to engage families and assist families to make use of services offered.

*(Interagency Guidelines for Child Protection S2.4.3 p53)*

### 11.3 Elements required for DoCS to make a best endeavours request

Under agreement with the Department of Community Services, the following elements will be present for best endeavours requests from DoCS Community Service Centres:

- DoCS has assessed that a child or young person is at risk of harm and may be in need of care and protection.
- DoCS is in the process of, or has undertaken, a risk assessment.
- A case plan has been developed which is provided with the written request to the Health Service.
- DoCS is involved in follow up and monitoring.

Under agreement between the Department of Community Services and NSW Health, the DoCS Helpline will be able to make best endeavours requests in limited situations which require:

- urgent mental health assessment or intervention
- forensic medical examination
- emergency medical treatment
- other crisis or trauma intervention.

These requests may not require ongoing follow up by the Department of Community Services, but will be limited to cases where a child or young person is assessed to be at risk of harm and a written request is made accompanied by a case plan. For these purposes, a 'crisis or trauma intervention' is a situation where there has been a critical incident such as a major accident and a crisis mental health response is needed.

All other best endeavours requests for a service will be made from the local Community Service Centre (CSC).

### 11.4 Monitoring requirements for section 17 and section 85 best endeavours requests for service

The introduction of 'best endeavours' requests for service is not intended to replace existing effective referral mechanisms between the Department of Community Services and NSW Health. A registration and monitoring system is being established to monitor the frequency with which 'best endeavours' requests for service are made to Health Services and their effectiveness and impact. It will be an electronic system loaded onto the NSW Health intranet.

The database will enable NSW Health and Area Health Services (AHS) to report:

- the total number of section 17 and section 85 requests received by the AHS each month
- requests which have not been responded to
- the services to which requests are being made
- the number of requests which are unable to be met and the reasons for this
- the time frames for responding to requests and providing the service.

Each Area Health Service is required to record information on all section 17 and 85 requests for service. A senior officer of the AHS will be responsible for monitoring unmet requests and resolving disagreements between Health services. Bi-monthly reports are to be sent to the NSW Health Department.

Information will be provided to the central register at three intervals:

- at the time the original request is received
- at the time of responding to DoCS in relation to whether the request is accepted
- six weeks after the request is accepted by the Health Service to report on the outcome to date.

## 11.5 Process for section 17 and section 85 best endeavours requests

Best endeavours requests will be sent by the Department of Community Services on the 'DoCS - section 17 Request for Service' form. The request will include a case plan and will be sent to the Manager of the Health Service from which the service is sought. When a request is received, a copy of the DoCS request must be immediately sent to the central register.

The Health Service Manager will send or transmit a written response to the Community Services Centre (CSC) using the 'NSW Health Response to Best Endeavours Request for Service' form. There is a copy of this form in Appendix 5. The response will state whether the service can be provided or not and the time frame for providing it. A copy of the response must also be sent to the central register.

Health Services are expected to respond as quickly as practicable to these requests. The service provider should contact the CSC within 2 working days of receiving the request to provide information on the status of the request. These referrals must be resolved promptly to enable the Department of Community Services to identify alternative agencies that can deliver the requested service.

If the Health service is able to provide the service, the CSC will then notify the family or individual and arrange for the necessary planning meetings to agree on the goals of the intervention.

If a Health service has agreed to provide a service to a section 17 or section 85 request, the central register should be updated after six weeks to include information on the outcome of the request. Please use the 'Update to Best Endeavours Request for Service Form' in Appendix 5.

## 11.6 Section 17 DoCS Helpline requests

In limited circumstances the DoCS Helpline may request 'best endeavours' responses, as outlined in chapter 11.3. These will usually be directed to Mental Health Services and Sexual Assault Services. If a 'best endeavours' response is sought by the DoCS Helpline, these requests will be directed to the Health service from which the service is sought.

Written confirmation will be sent to the central register, with a copy also being directed to the Helpline. The process for registering these reports is the same as for other section 17 requests. Verbal confirmation will be given to the DoCS Helpline as to whether the service can be provided.

The Health Service Manager will then send or transmit a written response to the DoCS Helpline using the 'NSW Health Response to Best Endeavours Request For Service' Form. The response will state whether or not the service will be or has been provided. A copy of the response must also be sent to the central register at the same time.

In these cases the written response will be faxed to the DoCS Helpline on 02-9633-7601 or on 02-9633-7633.

## 11.7 Criteria for accepting section 17 and section 85 best endeavours requests

A Health service should provide the services requested under section 17 of the Children and Young Persons (Care & Protection) Act 1998 unless:

- the service requested is not currently provided by the service
- the service requested is not consistent with the service responsibilities
- providing the service would prejudice the discharge of the service functions.

If a service is at capacity, priority should be given to section 17 requests on any waiting list unless there are demonstrable acute clinical reasons for other referrals to take precedence.

Concerns about the appropriateness of a request or the lack of information provided are not sufficient grounds to refuse to provide a service. If there are such concerns, the Service Manager should consult with the appropriate Department of Community Services Manager to discuss and resolve these issues.

Concerns that providing a service as requested may place Health workers at risk should also be discussed internally and with the appropriate Department of Community Services Manager to find out if a safe alternative means of providing the service is available.

Agreement to the provision of a service should not be made if it is considered that the safety of a Health worker will be placed at risk.

The Department of Community Services should be advised that provision of the service would be inconsistent with the Area Health Service's Occupational Health and Safety obligations. This reason for refusal to provide a service is likely to be rare and may mean that another agency may need to provide a service, such as the Police.

You should also consider whether the service could be provided from an alternative agency or site within the Area Health Service if this will meet the needs of the client. This can be negotiated between the managers of the Health Service in question. The service originally approached to provide the request retains responsibility for informing the Department of Community Services of the outcome of the request.

Area Health services need to establish procedures for senior staff to resolve differences in relation to responsibility to accept section 17 and 85 best endeavours requests. The responsibility for these requests lies with the Area Health Service, not just with individual services.

If the Health Service cannot accept the request, the Manager must inform the Department of Community Services of the reasons using the 'Response to Best Endeavours Request for Service Form' in Appendix 5.

It is then the role of the Department of Community Services to locate another appropriate service or consider reconvening a case planning meeting to identify alternative responses.

Area Health Services may make service specific agreements with the Department of Community Services in relation to priority groups.

# 12

## Other referrals from the Department of Community Services

In addition to section 17 and section 85 requests for service, Health workers may receive other referrals from the Department of Community Services (DoCS). These referrals fall into two categories:

- DoCS Helpline requests for assistance
- General referrals

### 12.1 Department of Community Services Helpline requests for assistance

The first type of referral is generated where there is no follow up required by DoCS. These requests are made in response to a caller whose assessed needs or requests can be met by offering a service not provided by DoCS.

DoCS will help the caller to contact the service provider by either giving them a letter of introduction or contacting the service for them. They will only initiate the contact if the caller has some difficulty accessing the service because of, for example, limited mobility or isolation issues or the caller has requested that DoCS initiate contact on their behalf. The 'best endeavours' principle does not apply in these cases.

### 12.2 General referrals from the Department of Community Services

There may be some referrals from the local office of DoCS that will not require ongoing monitoring by DoCS. The 'best endeavours' principle does not apply in these cases. These are cases where DoCS has established that risk of harm no longer exists but the family may need help to access services.

### 12.3 Worker safety

Safety factors must be considered by the DoCS in making referrals to Health services. DoCS has the responsibility to share information with Health services about any known risk of violence or other safety threats to staff or clients.

### 12.4 NSW Health responsibilities in relation to referrals

All Health services that receive a referral from DoCS must consider the possible existence of child protection issues when determining the priority to be given to the referral. Health services must have documented intake procedures that outline the need to prioritise those who are vulnerable, including referrals from DoCS involving possible or identified child protection issues. Clients must also consent to the provision of a service.

### 12.5 Referrals by the Department of Community Services to specialist physical abuse and neglect of children (PANOC) services

Specialist PANOC services accept referrals of children and young people assessed to be at high and medium risk of harm. Due to the large number of potential referrals, priority groups for referrals to specialist PANOC services have been agreed with DoCS

These priority groups are families with the following risk factors:

- a previous child death in the family from non-accidental injury
- the previous assumption of care or removal of the child or other siblings in the family

- serious physical or psychological injury as a result of physical abuse or domestic violence
- a child under 5 years where PANOC has occurred
- multiple PANOC reports about the child
- polysubstance abuse by the parents or caregivers
- a parent or child with a disability.

Referrals where a combination of any of these factors exist should be accepted as a higher priority by PANOC services. This could be, for example, a situation where there has been previous assumption of care of a child and there is polysubstance abuse by the parents or caregivers.

If referrals are received outside these priority groups that the PANOC Coordinator or Manager considers to be of a higher priority, they have discretion to accept that referral in consultation with DoCS. The PANOC Coordinator or Manager should record the reason for giving priority to that referral in the Health record of the referred child or young person.

Referrals to specialist PANOC services occur when DoCS has assessed that the child is at risk of harm and is in need of care and protection. Referrals to specialist PANOC services will only occur when a protective framework has been agreed upon by DoCS and the PANOC service and structures have been put into place to ensure the child is no longer at immediate risk of harm.

DoCS will be actively involved at the time of referral to specialist PANOC services, but may not remain actively involved with the family for the duration of the PANOC service. In such situations, a designated DoCS officer will be identified and the agreed process for monitoring roles and responsibilities will be stipulated in the case plan agreed at the time DoCS reduces contact with the family.

Due to the large numbers of potential referrals, other Health services such as Child and Family Teams, Child and Adolescent Mental Health Services or Youth Health Services will also be required to respond to referrals from these priority groups. It is likely that these referrals will be made under sections 17 and 18 of the Children and Young Persons (Care and Protection) Act 1998 requiring Health services to use their best endeavours to provide a service.

## 12.6 Process for accepting PANOC referrals

All referrals to PANOC services must occur through a case planning process. There must be a protection planning meeting involving DoCS, the Health service, the family and, where possible and appropriate, the child or young person.

Preliminary case planning should include a discussion between the referring DoCS officer and the Manager of the PANOC service or designated PANOC worker. This initial process is a means of gathering relevant information to determine whether the PANOC service is the most appropriate service and whether it is able to accept the referral. This process must not take the place of a protection planning meeting.

The protection planning meeting must occur before the PANOC Service provides a service to the child, young person or family. However the PANOC Service may negotiate with the family and the DoCS to meet the family before the protection planning meeting to begin the rapport building process.

Within six months of the referral, a review meeting must be held between the family, including the child or young person where appropriate, the designated DoCS officer and the PANOC service. The purpose of this review is to make sure that the family and services involved are aware of any progress made or to decide on new strategies if there are still protective concerns.

If a service is provided to a child, young person or family for more than six months, a review meeting must be held within each six month period.

## 12.7 Referrals by the Department of Community Services to sexual assault services for children under the age of 16 years

Sexual assault services provide counselling to children where the outcome of the DoCS risk assessment is that the child is at risk of harm and the assessment indicates that the child has been sexually assaulted.

This referral will be provided in writing to the Sexual Assault Service with the other outcomes of the risk assessment.

The case planning process between the Sexual Assault Service, DoCS and where relevant NSW Police will establish what protective and investigative action has occurred and what, if anything, needs to be addressed.

Counselling intervention with children under the age of fourteen years should not be provided until NSW Police or DoCS has attempted to interview the child.

NSW Police and DoCS will make the early interviewing of children a priority so that prompt support can be provided for the child without risk of contamination. Early referral to Sexual Assault Services by DoCS and Police will enable Sexual Assault Services to make immediate contact with non-offending caregivers and children over fourteen years to provide counselling in the crisis period.

If the child has not made a disclosure during a DoCS or Police interview, or the child has not been interviewed by DoCS or the Police, a case planning meeting will be called with the DoCS caseworker, a representative of the Sexual Assault Service and the relevant police officer.

The purpose of this meeting is to discuss and document:

- whether there is an intention to interview the child and when
- if the child will not be interviewed or has not disclosed, whether a belief can be formed that the child has been sexually assaulted
- the reasons why no police action is being taken at this stage, if this is the case
- the basis for re-opening the criminal investigation if this has been discontinued
- the timetable and process for review
- the tasks and role of each agency
- whether safety issues have been addressed.

If in this process a belief can be formed that the child has been sexually assaulted, and the other issues have been addressed, the Sexual Assault Service may proceed with providing counselling to the child.

## 12.8 Sexual assault presentations of children and young people to a medical service

If a child presents directly to an emergency department and there are reasonable grounds to suspect the child is at risk of harm as a result of being sexually assaulted, this should be reported immediately to the DoCS Helpline. The response and any examination will be coordinated by the Sexual Assault Service or Child Protection Unit.

If possible, medical examination of the child should be delayed until the child has been spoken to by an officer from the Police or DoCS. If necessary, an officer from DoCS or the Police will attend the service before the examination is done. This might include circumstances in which an urgent forensic medical examination is required and an interview with the child is necessary to establish the nature of the medical examination needed or to prevent the loss of other evidence.

Medical symptoms warranting immediate examination or treatment include pain, bleeding, discharge, bruising, possibility of pregnancy, prophylaxis and other forensic indicators. The necessary patient consent must always be obtained for any medical examination.

Referrals for urgent forensic examination may at times also be made directly from the DoCS Helpline.

The decision to provide a forensic medical examination at the time of presentation will be made by the Sexual Assault Service or Child Protection Unit counsellor and medical officer in consultation with the DoCS Helpline. The process for these examinations will comply with NSW Health Sexual Assault Policy and Procedures Manual. Before conducting the examination, appropriate consent of the child, young person or their parent or caregiver, or authorised consent from DoCS should be obtained.

Whether or not a child is examined at this time, counselling can be provided to the non-offending caregivers and children fourteen years and over. The Health service can later follow up the case with DoCS to ensure re-referral.

# Case plans

# 13

Health workers, including those who work with adults, may be asked to participate in case planning with Department of Community Services staff.

Case planning is the term that refers to all planning relating to the safety, welfare and well-being of a child, young person or their family. Case plans are designed to ensure there are no misunderstandings for a child, young person, family and practitioners about goals or responsibilities. If Health workers are asked by the Department of Community Services to attend a case planning meeting they should do so. Case plans that Health workers may be involved in include protection plans and support and management plans.

## 13.1 Protection plan

A protection plan is developed at a protection planning meeting and recommends intervention in child protection cases based on the conclusions drawn from assessments and investigations. The plan is prepared by practitioners with responsibilities for the care and protection of the child or young person after negotiating with the child, young person and their family. It specifically addresses the safety and care and support of the child or young person and may include criminal prosecutions and care proceedings.

## 13.2 Support and management plan

A support and management plan documents the proposed action to be taken to provide for a child or young person's care or protection. It defines:

- the action to be taken to provide the care, support and education necessary to sustain the safety, welfare and well-being of the child, young person and family
- the sequence of such action
- the agencies or practitioners responsible and the processes for review.

The plans are part of case planning and the concepts apply to different parts of the process. All planning should follow sound planning principles.

There may be less formal meetings convened to discuss aspects of a case, such as preliminary outcomes from assessments and investigations. These informal meetings do not replace the protection planning meeting or support planning meeting.

# 14

## Treatment and Assessment ordered by the Children's Court

### 14.1 Health Service responses to Children's Court orders

Under the Children and Young Persons (Care and Protection) Act 1998, the Children's Court can now make a range of orders to support children and young people and increase the likelihood that families will accept and participate in referrals to services. Health services have an important role in providing support services to children, young people and their families.

Requests from the Children's Court to Health services may be made under several sections of the Act. Orders for services will not be made without first consulting the Health service involved and agreement being reached that the service is both appropriate and available.

If a Health service is approached to provide services that may become part of a court order, the service should negotiate the terms of the order and period for which the order is to be made with the Department of Community Services. You will also need to negotiate the appropriate steps to take if an order has been made and either the child or family discontinue contact with the service or you are not able to continue providing the service.

The following sections 14.2 – 14.6 outline some of the Children's Court orders that require a response from Health services.

### 14.2 Section 123-132 Compulsory Assistance Order

Compulsory Assistance orders are made by the Children's Court under sections 123-132 as a form of intensive care and support for the child or young person which protects them from suicide or other life threatening or serious self destructive behaviour. Due to the serious nature of such an order, Compulsory Assistance can only be applied for by the Director-General of the Department of Community Services. Compulsory Assistance orders

can only be for a three month period, with no more than a three month extension. Interim Compulsory Assistance orders can only be granted for up to 21 days.

When considering this order, the Children's Court must be satisfied that:

- the child or young person will receive services that will help them to deal with the problems that have led them to present a danger to themselves
- the agency that will be required to provide intensive supervision of the child or young person has indicated to the court that it is able to allocate the necessary resources.

The Children's Guardian must monitor the circumstances of the child or young person subject to the order.

Health services that may be requested could include drug and alcohol treatment, mental health or other counselling services.

This provision of the Children and Young Person's (Care and Protection) Act 1998 is proposed to commence in mid 2001.

### 14.3 Section 60-91 Court Endorsed Care Plan

Care plans are covered by sections 60-91 of the Children and Young Persons (Care and Protection) Act 1998. A care plan is a document that sets out the services required by a family and the parenting arrangements for a child or young person that are required to reduce risk of harm where a child has been removed. Care plans should be made as far as possible with the agreement of the child or young person and their family. This may occur through direct negotiation by the Department of Community Services or by using alternative dispute resolution processes. A care plan may be registered in the Children's Court. This may also involve a care application for re-allocation of parental responsibility.

Health workers may be asked to assist in this process by attending case conferences or protection planning meetings. It is important that Health workers attend these meetings if asked, especially if a Health service is proposed to be a component of the care plan.

## 14.4 Section 85 Restoration Orders

If a child is removed from the care of their parents, Health services may be asked to assist with support services to facilitate the restoration of a child or young person to their family. If a child is removed from the care of their parents and restoration is likely, the Department of Community Services must develop a restoration plan outlining what steps the parents must take before the child can safely be returned. Drug and alcohol or mental health programs are examples of elements of a restoration plan that health services may be asked to provide.

Section 85 of the Act requires government departments or funded agencies to use their best endeavours to provide services that are an element of a restoration order. A high priority should be given to these requests and they should be responded to using the same procedures for section 17 requests. These are outlined in chapter 11 of this manual.

## 14.5 Section 75 Therapeutic or Treatment Program Orders (Sexually Abusive Behaviour)

The Children's Court may make an order under section 75 requiring a child aged less than 14 years to attend a therapeutic program relating to sexually abusive behaviours, and require the parents of a child to take whatever steps are necessary to enable the child to participate in a treatment program.

If the child is over ten years old, a referral may be made to designated Health programs for adolescents who sexually offend, such as New Street at Parramatta and Trek at the Central Coast.

If the child is under ten years old and is a victim of sexual assault, Area Health Services are responsible for making sure that these services are available through Sexual Assault Services. If the child is not a victim, services are provided by trained counsellors in Child and Family and Child and Adolescent Mental Health Services.

## 14.6 Section 53 Examination and Assessment Orders

Under section 53 the Children's Court may make an order for the physical, psychological, psychiatric or other medical examination or assessment of a child or young person. The Department of Community Services will apply to the court for the order. A range of Health services may be approached to provide these assessments.

Assessment orders will only be made where the information is necessary to plan and provide for the safety, welfare and well-being of the child or young person. When making assessment orders, the court must consider:

- whether the proposed assessment is likely to provide relevant information that is unlikely to be obtained elsewhere
- whether any distress the assessment is likely to cause the child or young person is outweighed by the value of the information that might be obtained
- any distress already caused to the child or young person by any previous assessment undertaken for the same purpose
- any other matter the court considers relevant.

The Children's Court may also order an assessment of a person's capacity to parent a child or young person, but only if that person consents to the making of the order. It is appropriate for a Health worker who is already providing a service to a parent to produce an assessment report on an aspect of the parent's capacity to parent related to their field of expertise.

## 14.7 Section 58 Children's Court Clinic

The role of the Children's Court Clinic in child protection is to provide independent assessments to help the Children's Court discharge its roles and responsibilities. If the Children's Court makes an assessment order, the Children's Court Clinic may prepare and submit an assessment report about the child or young person. These assessments are independent, in the sense that the expert preparing the report is not on the side of any of the parties to the proceedings.

Section 58 also permits the Children's Court Clinic to inform the Children's Court that it is unable or unwilling to prepare the assessment report, or that it is of the opinion that it is more appropriate for the report to be prepared by another person. A Health service, for example, may be asked to provide an assessment of a child or young person if it is considered that this is more appropriate.

Health workers have considerable expertise and a nominated Health worker may be the most appropriate person to make an assessment for the Children's Court and provide a report. Prior contact with a child, young person or family may facilitate a Court assessment and minimise repeat assessments but it may also compromise independence. This balance should be discussed with the Children's Court if Health workers are approached to provide a court assessment.

The requirements of forensic assessments and court reports are usually different from those of most clinical reports. If a Health service or worker is approached to provide an assessment and the service has the capacity and expertise to provide the assessment and prepare the report, this should be provided. When considering capacity to accept referrals, the core service delivery functions of the health service should not be compromised.

# Child protection issues in relation to medical assessment and treatment

# 15

The Children and Young Persons (Care and Protection) Act 1998 contains a number of provisions relating to the provision of medical treatment and the medical examination of children. This section explains these provisions and provides general guidance on conducting a medical examination of the genital, anal or breast regions of a child.

Generally, treatment should not be provided unless it is lawfully authorised under the terms of the Act or consented to by the parent or caregiver of the child. Please refer to the NSW Health Circular 99/16 Patient Information and Consent to Medical Treatment.

## 15.1 Medical examination of children in need of care and protection

Under section 173 of the Children and Young Persons (Care and Protection) Act 1998, the Department of Community Services or Police may serve a notice on a person who has the care of a child or young person deemed to be in need of care for a medical examination. This notice requires the person to present the child or young person to a specified medical practitioner within 72 hours, or sooner if deemed necessary by the Department of Community Services, for a medical examination.

If the person fails to comply with this notice, the child may be presented by the Department of Community Services or by the Police. From the time the child or young person is presented for examination until it has been completed, or until 72 hours has expired, the Director-General of the Department of Community Services is deemed to be the parent of the child or young person for the purpose of consenting to the medical examination.

Before the Department of Community Services refer a family for a medical examination for a child deemed in need of care, they will contact the medical practitioners, hospital, or in the case of sexual assault, a Sexual Assault Service and arrange the time and place for the medical examination.

A medical practitioner conducting a section 173 examination must provide the Department of Community Services or the Police with a written report of the examination. Reports made under section 173 should be provided without charge by Health workers. A medical practitioner who transmits a report prepared under these circumstances is protected under the Act from legal action in relation to allegations of professional misconduct and defamation.

## 15.2 Emergency medical treatment

Under section 174 of the Children and Young Persons (Care and Protection) Act 1998, a medical practitioner or dentist may carry out medical or dental treatment on a child or young person, without the consent of the child, young person or their parent, if they are of the opinion that it is necessary as a matter of urgency to carry out the treatment on the child or young person to save their life or to prevent serious damage to their health.

## 15.3 Examinations in situations of sexual assault

Medical examinations to assess for sexual assault must only be provided by the medical service associated with a Sexual Assault Service or level 6 hospital Child Protection Unit. You must consult with the Department of Community Services Helpline before carrying out a forensic medical examination, in accordance with NSW Health Sexual Assault Policy and Procedures. Relevant consents and authorisation must be obtained before carrying out a forensic medical examination and the process documented in accordance with the Child Sexual Assault Medical Protocol.

## 15.4 Medical examination of the genital, anal and breast areas

Medical examinations of all children and young people should occur in a supportive and protective environment. This is particularly important when conducting medical examinations and treatments of the genital, anal or breast areas. These examinations should only be done if it is clinically necessary for the health care of the child or young person.

If medical practitioners assess that examination or treatment of the genital, anal or breast areas is necessary, the following procedures should be followed:

- a support person of the child's choosing must be present at all times
- young people must be given the option of having a support person present
- the child or young person and support person must be given information about the need for, and any effects of, the examination or treatment before it starts so that informed consent is obtained
- the examination should be made with a minimum number of medical staff in attendance and done in the least intrusive manner possible.

# Systems and procedures to be established by Area Health Services

# 16

This chapter provides Health Services with guidance on the systems, policies and procedures they need to put in place to ensure they are able to respond effectively to their child protection responsibilities and the responsibilities of their workers.

## 16.1 Health services intake procedures and prioritisation of child protection referrals

When determining the priority to be given to any referrals received by a Health Service, consideration must be given to the existence of possible child protection issues. Intake procedures for services providing intervention primarily for adult clients should take into account presenting issues that may impact on the care of any children that the client may have. Area Health Services are responsible for making sure that Health Services have documented intake procedures that include the prioritisation of the most vulnerable and consider possible child protection issues.

If the provision of the service may play a role in preventing or mitigating the abuse of a child or young person, reasonable efforts to meet these referrals must be made by all Health services.

## 16.2 Central register for section 17 and 85 best endeavours requests

The Department of Community Services (DoCS) will make referrals for clients where there is a risk of harm to the child or young person within the family, and may request that Health services use their best endeavours to meet these requests. Area Health Services must ensure that service providers use their best endeavours to respond to requests from DoCS when these requests meet agreed criteria, and that demand and responses for these services are monitored by the Area Health Service. Area Health Services will establish a central register for monitoring and reporting on responses to these requests, as well as systems to ensure prompt resolution of disagreement in relation to requests.

## 16.3 Centralised system for receipt and response to section 248 requests

Each Area Health Service is responsible for establishing a centralised system for responding to section 248 Requests for Information by the Department of Community Services. This system must ensure that accurate and timely information is provided to the Department of Community Services about children and young people where there is a concern for their safety, welfare and well-being. For more information on the centralisation of these requests, please see Chapter 9.

## 16.4 Provision of child protection training for Health workers

Area Health Services are responsible for providing child protection training for Health workers. Each Area Health Service must have an ongoing training strategy to ensure that Health workers receive information about child protection that is relevant to their position.

Specialist training for Health workers with key child protection roles is available through the Education Centre Against Violence.

## 16.5 Flagging of child protection health records

Area Health Services are committed to implementing a system for the flagging of client files of families where a report of suspected risk of harm has been made. This was outlined in the previous *NSW Health Child Protection Policy and Procedures Manual 1997*.

This system will alert Health workers to concerns about children who are at risk of harm. The implementation of this system will meet recommendations made by the *1997/1998 Child Death Review Team Report*.

## **16.6 Provision of primary, secondary and tertiary services in the area of prevention of abuse**

Area Health Services are responsible for providing services in the area of primary, secondary and tertiary prevention of child abuse. They are required to provide a specialist response through a range of generic, community and hospital based services as well as specialist in-patient paediatric units.

These services will include:

- counselling - crisis and follow up services
- access to 24 hour 7 day a week medical diagnosis, assessment and management
- child and family assessments which assess the strengths and weaknesses of the family and its supporting environment and its capacity to protect the child or young person from further abuse or neglect.

## **16.7 Provision of appropriate services for children and young people at risk of harm.**

Area Health Services are responsible for providing physical, emotional and sexual abuse and neglect services for children and young people.

Each Area Health Service will have at least one designated paediatric unit that meets the Level 4 role delineation requirements. Tertiary child protection services (Level 6 delineation) which include comprehensive paediatric medical, surgical and intensive care are located at John Hunter hospital, the Children's Hospital at Westmead and Sydney Children's Hospital. Medical officers and paediatric sub-specialists are available for medical consultation and second opinions to staff across NSW under the following arrangements:

- John Hunter Hospital Northern NSW
- The Children's Hospital at Westmead Western NSW
- Sydney Children's Hospital Southern NSW

Area Health Services are responsible for ensuring that the level of service provided meets the role delineation criteria set out by the NSW Health Department (please see Appendix 3), and that local protocols clearly define the role and procedures for referring to another level of the Health service.

## **16.8 Provision of services for 24 hour medical care**

Area Health Services are responsible for providing 24 hour, 7 day a week medical care for children and young people who present with clinical conditions that may have been a result of physical or emotional abuse or neglect, or give rise to suspicions that they may have been physically or emotionally abused or neglected. If children or young people present to a Health service and there is suspicion that they may have been abused, the child or young person should be treated as an urgent case.

## **16.9 Provision of services for children who exhibit sexually offending behaviour**

Providing services for children under ten who exhibit sexually offending behaviour is a specialist response. It is the responsibility of each Area Health Service to ensure that this service response is available through both Sexual Assault and trained Child and Family and Child and Adolescent Mental Health Services in a range of locations in the Area Health Service.

Area Health Services must have a designated coordinator who is responsible for coordinating service provision to children under ten years who exhibit sexually offending behaviour. The Area Coordinator has to provide quarterly data to the Department of Health and coordinate the provision of training to staff. The Education Centre Against Violence provides training and resources for this area of work.

# Responsibility of service managers

# 17

The key responsibilities of Service managers are:

- assisting staff to access and comply with this document
- developing, implementing and updating local procedures which include:
  - intake procedures prioritising children and young people at risk of harm referred by the Department of Community Services
  - the participation of Aboriginal and Torres Strait Islander children or young people in assessment and intervention decisions
  - the identification of children and young people at risk of harm
  - case management, where appropriate, of children and young people at risk of harm
  - reports to the Department of Community Services
  - reporting and recording information
  - legal responsibilities
  - confidentiality
  - service planning for children and young people referred by the Department of Community Services in the context of best endeavours.
- organising and coordinating child protection training for staff which includes early identification, responsibilities and procedures for reporting, providing direction and support, seeking necessary advice for staff, in relation to discussions to report suspected risk of harm to a child
- providing and developing professional support, debriefing and supervision for staff working with children, young people and families where child protection concerns are identified
- developing an effective system for reviewing the management of child abuse cases with health staff
- ensuring inter-agency collaboration with other agencies involved with child protection
- notifying staff of the designated paediatrician or medical practitioner available to provide support and guidance to community nursing and hospital staff, ensuring that on-call rosters are developed and that linkages with Level 4 and Level 6 Child Protection Units are adequately defined
- providing staff with information about the role and location of the Sexual Assault Service Coordinator and PANOC Coordinator so they can provide consultation and advice about child protection training.

# 18

## Issues for specific program areas

### 18.1 Emergency departments

Emergency department staff include medical, nursing, social work and allied health, administration and support services staff. Hospital emergency departments are often the first service accessed by families or caregivers with children or young people at risk of harm.

#### Issues and processes

It is important that Health workers in emergency departments are always alert to indicators of abuse when providing care for children, young people and their families or caregivers. A child or young person may present for a variety of reasons and may have attended other emergency departments in the past with other injuries. All Health workers have responsibilities for reporting to the Department of Community Services if they have reasonable grounds to suspect that a child or young person is at risk of harm. Referrals should be made to hospital social workers at the same time that a report is made to the Department of Community Services.

Fractures of bones and soft tissue injuries should be considered an indicator of risk of harm when in the context of other indicators. If other indicators exist, or you have reasonable grounds to suspect risk of harm as a result of inconsistencies in the explanation of an injury, you must make a report to the Department of Community Services. If fractures have been detected in a non-ambulatory infant, a full skeletal survey should be done to check if there are any previous fractures.

In cases of non-accidental injury where there are concerns about risk of harm to a child or young person, it is good practice for a psychosocial assessment to be conducted. Referrals should be made to hospital social workers at the same time that a report is made to the Department of Community Services. A psychosocial assessment should also be provided if requested by the Department of Community Services. Please see chapter 15 for more information about medical presentations and chapter 5 for indicators for recognising abuse and neglect.

Adults who present to emergency departments with injuries following domestic violence may be the parents or caregivers of children and young people who are at risk of harm as a result of the violence. Concern about risk of serious physical or psychological harm as a result of exposure to domestic violence is grounds for making a report to the Department of Community Services. For more information on recognising abuse and neglect, please see chapter 4.

Emergency department workers may encounter situations where a parent or caregiver refuses permission for a child or young person to be admitted to hospital or refuses to have relevant investigations such as x-rays or blood tests done. If you have reasonable grounds to suspect risk of harm to a child or young person as a result of 'failure to provide necessary medical care', you should make a report to the Department of Community Services. If you treat a child or young person without consent in an emergency situation – that is, to save the child or young person's life or avert immediate risk or serious injury – you are not acting unlawfully.

If a child, young person or their family or caregiver have presented and you are unsure if a report should be made to the Department of Community Services, you should consult your Manager or your Area PANOC Service. The Department of Community Services Helpline is also available for consultation. If sexual assault is suspected, consultation and/or referral to the Sexual Assault Service or Child Protection Unit must occur.

If medical practitioners have concerns about injuries to a child or young person, they should continue their routine examination of the child to ensure that appropriate medical care is provided.

## 18.2 Other hospital facilities

Hospital staff includes medical, nursing, social work and allied health, administration and support services staff who work in a range of wards and facilities across Area Health Services. Hospital staff are an important first point of contact in many cases of suspected or actual abuse and neglect.

### Issues and processes

Hospital staff are responsible for reporting children and young people at risk of harm to the Department of Community Services. A child or young person may present for a variety of reasons which may not initially appear to relate to abuse or neglect or may have visited other hospitals in the past.

Due to the extent of their contact with families, hospital workers are well placed to identify children and young people at risk of harm. They have opportunities to recognise risk of harm related to neglect and failure to provide necessary medical care, domestic violence and emotional abuse. Paediatric nurses are particularly well placed to identify risk of harm to a child or young person in their care because they can observe family dynamics and interactions. They may also receive disclosures of abuse from parents.

In cases of non-accidental injury where there are concerns about risk of harm to a child or young person, it is good practice for a psychosocial assessment to be conducted. Referrals should be made to hospital social workers at the same time that a report is made to the Department of Community Services. A psychosocial assessment should also be provided if requested by the Department of Community Services. Please see chapter 15 for more information about medical presentations and chapter 5 for indicators for recognising abuse and neglect.

Hospital staff may encounter situations where a parent or caregiver refuses permission for a child or young person to be admitted to hospital or refuses to have relevant investigations such as x-rays or blood tests done. If you have reasonable grounds to suspect risk of harm to a child or young person as a result of 'failure to provide necessary medical care, you should make a report to the Department of Community Services.

## Telephone consultation on child protection matters

### Southern NSW

The Sydney Children's Hospital Child Protection Service provides telephone advice on child protection for medical practitioners and other health workers. You can contact them on 02 9382 1412 during office hours. The on-call paediatrician can also provide telephone consultation after hours - ring the hospital switchboard on 02 9382 1111.

### Western NSW

Medical practitioners and other health workers can access the Child Abuse Teleconferencing Consultancy Service based at the Child Protection Unit at the Children's Hospital at Westmead. They provide audio or teleconference assessment advice in situations where children and young people have been harmed. Contact them on 02 9845 0000 to arrange an appointment within office hours.

### Northern NSW

Telephone consultation on child protection matters for Area Health Services in northern NSW is provided by the paediatrician on call for child protection at John Hunter Children's Hospital, Newcastle on 02 4921 3000.

## 18.3 Maternity departments

Maternity departments include antenatal, intranatal and postnatal staff. Comprehensive antenatal assessment and care planning for women during pregnancy includes physical, medical, mental health and psychosocial elements. It should also include the collection of information relating to parenting capacity. Maternity staff need to conduct comprehensive assessments so that appropriate and timely assistance and support can be arranged.

### Issues and processes

Nursing staff should, where appropriate, involve the social worker and doctor in a joint assessment leading to a thorough psychosocial assessment. Parents should be involved in this process where appropriate.

A thorough assessment of a woman's family, risk factors and strengths both during pregnancy and the postnatal period will help identify the supports that may be needed to make sure that an infant will be nurtured and protected and families are linked to a network of services.

Maternity staff should be aware that domestic violence often begins or escalates during a woman's pregnancy. When responding to women suffering domestic violence, you should refer to local domestic violence protocols. If routine screening for domestic violence in antenatal services has been introduced in line with the NSW Health Domestic Violence Policy, this will be an important child protection strategy.

Maternity staff should also be aware of significant changes in the mental state of a mother. In particular, you need to look for signs of post-natal depression or post-partum psychosis. If there is concern about the mother's mental health or behaviour, an assessment of the care and safety needs of the child should be made as well as an assessment of the mother's mental health and safety.

Pre-natal reports may be made before the birth of a child if there may be risk of harm after the child is born. The principle of pre-natal reporting is to provide an opportunity for early support and assistance to pregnant women if their child may be at risk of harm after he or she is born. It also helps to reduce the likelihood of the need for out-of-home care.

Pre-natal reporting may be particularly helpful for pregnant women in domestic violence situations or with mental health or drugs in pregnancy issues because reporting can provide the catalyst for assistance. However, pre-natal reporting should only be used if there are clear indications that the infant may be at risk of harm. Reporting is not intended to be used as a punitive measure against women under stress. Maternity staff need to involve and consult with other relevant health services to assist with the care of the mother and her child.

## 18.4 Early childhood nursing services

Early childhood nursing is a primary health care service for infants, children and families with children in the community. The care provided is ongoing and continuous rather than episodic and focuses on promoting the health of children and families through the use of a relationship and anticipatory guidance approach. Early childhood health staff work with midwives to provide integrated services to women with children and their families.

### Issues and processes

Early childhood nursing staff are in a unique position to identify a child who is at risk of harm from abuse or neglect. They are also in a good position to identify mothers who may be at risk or who are suffering from post-natal depression or domestic violence which may put their children at risk of harm from abuse or neglect.

If you become aware, or have reasonable grounds to suspect, that a baby or other children such as toddler siblings are at risk of harm from abuse or neglect, you must report your concerns to the Department of Community Services.

It is important that you continue to support the parent or caregiver and work with the Department of Community Services to formulate a care plan.

Early childhood services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.5 Nursing in schools

Nurses working in schools concentrate on the general well-being of children. They contribute to school health through screening, immunisation and the education of teachers and parents. In some schools, NSW Health nurses and allied health workers provide health care services to students with disabilities.

### Issues and processes

If nurses or allied health workers in schools become aware, or have reasonable grounds to suspect, that a child or young person is at risk of harm from abuse or neglect, they should discuss their concerns with the school principal. They should then decide who will make the report to the Department of Community Services.

The Nursing Unit Manager must be informed of the action taken and the decision and any other relevant information recorded in the client file.

If there is disagreement between the Health worker and the school principal, the risk of harm should still be reported if the Health worker has reasonable grounds to suspect that the child is at risk of harm. In these situations, the Health worker should also document and inform their Nursing Unit Manager of the disagreement and action taken.

## 18.6 Public oral health services

Preschool children and children and young people up to 18 years old may receive public oral health care. This may include oral health education and an oral health assessment in school as well as clinical care in public clinics.

Public clinics are located in school grounds, public hospitals, community health centres and other sites. Clinical care may be provided by dental therapists or by dentists.

### Issues and processes

When children or young people present to oral health professionals with orofacial trauma, you must consider issues of harm and abuse as part of your assessment.

The head and orofacial region (including intraoral structures) are common sites of trauma from all forms of child abuse. Clinical experience indicates

that around 40% to 50% of cases of child abuse include orofacial trauma (John, Messer, Arora et al 1999). Many of these injuries such as bruising, lacerations, burns and bites are extraoral and are obvious without an intraoral examination. Intraoral injuries tend to be reported less frequently than other injuries of the orofacial region. They may be overlooked compared to more obvious injuries or because medical practitioners are not familiar with intraoral examinations. Dental injuries include fractured teeth, oral bruises, oral lacerations, jaw fractures and oral burns. Injuries to the orofacial region are much more common among cases of physical abuse compared with other forms of abuse.

You must also consider issues of neglect when assessing children with untreated, rampant caries, with untreated pain or infection, and children who have a history of poor dental attendance (Raphael, 1999). You may also be in a position to recognise whether a child or young person is at current risk of harm.

Oral health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.7 Community health centres

Community health centre staff include all staff employed at a community health centre such as counselling staff, intake staff, nursing and medical staff, speech therapists, dental health workers and managers.

Community health centres provide a range of services for children, young people, adults and families. These services may include speech pathology or occupational therapy services, child health nursing for children and their families, and assessment and treatment services for children and their families for a range of behavioural, emotional and physical problems including sexualised behaviour by children who are not victims of sexual assault. Community health centres also provide services for children and young people where abuse has occurred or is at risk of occurring.

## Issues and processes

Concerns about risk of harm to children and young people may arise at community health centres during the course of assessment or treatment for another issue. This may be when the Health worker is working with a parent of a child or with another family member who may care for or have contact with the child or young person. The Health worker may also form concerns about risk of harm to a child or young person when working directly with the child or young person or through information received from another child or young person.

During an episode of treatment, a child, young person or family member may disclose abuse that has occurred in the past or in the present. If there are reasonable grounds to suspect that a child or young person is at risk of harm, you should report the disclosure to the Department of Community Services. If the risk of harm issues relate to specialist health services, such as drug and alcohol or mental health issues, you should refer to the specific program areas in this Chapter when making a decision to report.

It is important that you continue to support the parent or caregiver and work with the Department of Community Services to formulate a care plan.

Community health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.8 Child, adolescent and family services

Child, adolescent and family services provide assessment and treatment services for children, adolescents and their families for a range of behavioural, emotional and physical problems. These services may include individual and co-joint counselling, speech pathology or occupational therapy services, and child health nursing for children and their families.

Child, adolescent and family services play an important role in providing services for children and young people where abuse has occurred or is at risk of occurring. In situations where sexual assault has not been positively identified, but a health service is considered appropriate to help a child or parent, referral may be made to an appropriate child, adolescent and family service.

## Issues and processes

Child, adolescent and family workers are ideally placed to recognise concerns about the safety, welfare and well-being of children and young people. Clinical experience suggests that there are links between childhood disorders such as attention deficit disorder, conduct disorder, anxiety disorders and child abuse and neglect (Graziano and Mills, 1992; Glod et al, 1996; Smith, O'Connor and Berthelson, 1996).

Additionally, children exposed to domestic violence may also display a number of behavioural and emotional problems that can be linked to the effects of living in a climate of fear and intimidation. These children are often presented to child, adolescent and family services for counselling and you need to consider whether their problems are linked to an experience of abuse or other possible risk of harm issues.

Child, adolescent and family workers can also play an important role in working in partnership with families where abuse or neglect has occurred or is occurring. It is good practice to highlight the constraints of confidentiality at the first contact with all children and their families as part of any explanation of the service that may be provided. It is also useful to involve children and families in making decisions as appropriate should the need to report risk of harm to children arise, as children and families who participate in decisions about their lives are more likely to support the decisions made. It is often helpful to assume that clients may wish to participate more actively in resolving difficulties that place their children at risk.

Child, adolescent and family services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.9 Youth health services

Youth health services provide a range of services for children and young people aged between 12 and 24 years. These services may include counselling and casework services, health promotion, nursing and medical services, drug and alcohol counselling, counselling for children and young people who are at risk of harm or where abuse has been identified, counselling for children and young people where sexual assault has not been positively identified, outreach services and needle exchange services.

Some youth health services target children and young people who are homeless or who are at risk of homelessness and provide counselling for children, young people and their families.

### Issues and processes

Youth health workers have a great deal of contact with children and young people at risk of harm. Concerns about risk of harm may develop in the course of working with either a child or young person on an individual basis or as part of providing health promotion activities to children or young people.

Clinical experience suggests that there are links between previous experiences of abuse and concerns such as homelessness, suicide, self harming behaviour, drug and alcohol problems or mental health issues. Many of these feature in the presentations of children and young people to youth health services. When assessing the child or young person's difficulty, you need to consider whether their problems are linked to a previous or current experience of abuse. Young people may have had past experiences of abuse and have removed themselves from the situation, but have younger siblings that may currently be at risk of harm (Chandy, Blum and Resnick, 1996; Martin, 1996; Bayatpour et al, 1992; Kaplan et al 1997).

It is important that children and young people accessing the service know at the outset their rights to, and the restrictions of, confidentiality. It is good practice to highlight these issues as part of any explanation of services that may be provided.

It is also useful to include a child or young person in making decisions if appropriate should the need to report risk of harm arise. Children and young people are more likely to actively participate in a process that is transparent and includes their ideas and concerns.

Youth health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to Section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.10 Drug and alcohol services

People with alcohol and other drug related problems will have different needs throughout the duration of their drug use and will require access to a range of services to maximise the outcome of any particular treatment episode.

A range of drug and alcohol services are available for people with problematic substance use across a number of different settings. These services may include prevention and community development programs, early and brief intervention, assessment and referral, counselling and case management, detoxification, residential programs and substitution therapies such as methadone.

### Issues and processes

People presenting for drug treatment experience, to varying degrees, a range of social and health problems. Many of those with severe dependence problems tend to be unemployed, have limited formal education, have been involved in crime or exposed to the criminal justice system, and have poor social skills and support networks. They are often homeless or have poor housing, experience mental health problems and poor health, and have a history of abuse or trauma. Given the complexity of substance dependency and misuse problems, there is no one single 'cure' for drug dependence. The

success of any intervention will depend on the extent to which these social, health and economic factors are addressed.

Alcohol and other drug use in a family does not, in itself, indicate child neglect or abuse. However the risk of child abuse and neglect is higher in families where parents or caregivers have significant problems with alcohol or other drugs. Problematic alcohol and other drug use is one of the factors that may contribute to children being at risk.

All health professionals working with clients who have drug and alcohol problems need to be aware that the safety, welfare and well-being of any children within their care is paramount. Staff who are involved with counselling or treating people with alcohol and other drug issues need to be pro-active in making routine enquiries about their capacity to cope with the care of the children. All assessments should include questions to find out whether the client has any children in their care and if there are any concerns about the care of these children.

Drug and alcohol services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## **18.11 Child and adolescent mental health services**

Child and adolescent mental health services provide specialist assessment and treatment for children and young people affected by severe and complex mental health problems and disorders. Consultation and liaison with other services and agencies is an important part of their role.

Prevention and early identification of abuse and neglect, and assessment and treatment for children and young people with severe and complex mental health problems as a result of abuse or neglect are also part of the role of child and adolescent mental Health workers.

## **Issues and processes**

All staff need to be aware that the safety, welfare and well-being of children and adolescents is paramount. If during assessment, care planning or treatment you have reasonable grounds to suspect that a child or young person is at risk of harm of abuse or neglect, you are responsible for reporting your concerns to the Department of Community Services.

Clinical assessments may identify disruptive and emotional difficulties in toddlers and children ranging from mild to severe. Children may present with symptoms consistent with, or similar to, the effects of abuse such as heightened arousal and inattention or anxiety syndromes such as separation anxiety.

A thorough assessment of a family's risks and strengths will help to identify the supports that may be needed to ensure that a child or adolescent will be nurtured and protected and that families are linked to a network of services.

During intervention, you need to be aware of the family and living context of a child or adolescent client and the capacity of parents or caregivers to care for the child or young person. You may need to respond to the existence of domestic violence which may be grounds for reporting to the Department of Community Services. This should occur as a critical component of the mental health response.

During intervention, children and young people may also disclose abuse or neglect. In addition to reporting, you may need to liaise and consult with other services and agencies to ensure that children and adolescents receive appropriate care and support.

Child and adolescent mental health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.12 Adult mental health services

Mental health services provide comprehensive specialist mental health care for people with mental health problems and disorders. Consultation and liaison with other services and agencies is an important part of their role.

### Issues and processes

All staff working with adult clients who have mental health issues need to be aware that the safety, welfare and well-being of any children in the care of their clients is paramount. During assessment, mental health staff need to ask questions to find out whether a client has any children in their care. If during the course of assessment, care planning or treatment you become aware or have reasonable grounds to suspect that a child or young person is at risk of harm, you are responsible for reporting your concerns to the Department of Community Services.

Comprehensive assessment and care planning for adult clients includes collecting information on their family status and assessing the formal and informal support systems available to them. Client's roles as parents or caregivers should be considered as part of mental health assessment and care planning.

Also, staff who are involved with counselling or treatment of people with mental health issues need to be pro-active in making routine enquiries about their capacity to cope with the care of the children. This includes case planning for occasions when a parent is unable to care for their children, information for families on mental health issues, and ensuring that families are linked to support services when they need them.

If a parent or caregiver is experiencing an acute mental health crisis, you have to consider the needs and circumstances of any children and young people. Liaison and consultation with other services and agencies may be necessary to ensure that they receive appropriate care and support.

Health workers are also required to consider possible risk of harm to an unborn child of a client or a client's partner. The capacity to parent needs to be considered so that adequate assistance and support can be offered. A thorough assessment of a family's risks and strengths will help identify the supports that may be needed to ensure that an infant will be nurtured and protected and that families are linked to an appropriate network of services.

Mental health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service, involvement in case planning, providing assessments and providing services which may be linked to a court order. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## 18.13 Sexual health services

Health workers who work in specialist sexual health services are often involved in clinic-based and outreach work which targets difficult to reach population groups. The range of services provided usually includes sexually transmissible disease (STD) assessment and counselling as well as needle and syringe program (NSP) services.

### Issues and processes

#### Children and young people who access a service

Sexual health service workers must be aware that the safety, welfare and well-being of children and young people is an essential consideration during work with children, young people, parents or caregivers. Sexual health service delivery should be directed at achieving a balance between strategies which minimise the risk of transmission of infectious diseases and promote the health of sexual health service clients and strategies which minimise risk of harm to children and young person.

Children who engage in sexual activity may be at risk of harm if their participation is not consensual peer activity. A child who has been forced or intimidated to participate in non-consensual sexual activity is a victim of sexual abuse. If you have reasonable grounds to suspect this has occurred, the child should be reported to the Department of Community Services as a child at risk.

Even if a child has reported that their involvement is consensual, they may still be at risk of harm particularly if they are very young or the sexual activity is not peer activity. When taking a sexual history from a child, make sure you assess the nature of the activity (peer, non-peer) and the extent to which the child's participation is consensual or the result of intimidation or duress. This will help you assess if the child is at risk.

A child who is a sex worker is at risk of harm as is a child who is an injecting drug user (IDU). If the name of a child is not known (as is generally the case given the anonymous nature of service provision), Health workers must meet their reporting obligations by providing the Department of Community Services with a description of the client. It is important to note that sterile injecting equipment and condoms should be made available to any person who is currently involved in injecting drugs or sexual activity, regardless of their age.

### **Parents or caregivers who access a service**

Injecting drug use may leave parents and caregivers unable to provide appropriate physical, psychological or emotional care for their children. Suspicion of risk of harm is based on your observations and knowledge of the situation of the child. If you believe that a child who has an IDU parent or caregiver is at risk of harm, then you must make a report to the Department of Community Services.

Sexual health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to section 17 requests for a service and providing assessments. You may also need to provide services to parents, caregivers and families and respond to section 248 requests for information.

## **18.14 Needle and syringe program services**

Health workers who work in needle and syringe program services are often involved in outreach work which targets difficult to reach population groups. Maintaining contact with these target populations is essential to achieve primary health care and public health objectives.

## **Issues and processes**

Needle and syringe program workers must be aware that the safety, welfare and well-being of children and young people is an essential consideration during work with children, young people, parents or caregivers. The effects of injecting drug use may leave parents and caregivers unable to provide appropriate physical, psychological or emotional care for children. A child or young person who is an injecting drug user is also at risk of harm.

Needle and syringe program service delivery should be directed at achieving a balance between strategies which minimise the risk of transmission of infectious diseases and promote the health of injecting drug users (IDUs) and strategies which minimise risk of harm to children and young people.

A child who is injecting drugs should be considered at risk of harm and must be reported to the Department of Community Services and referred to drug and alcohol services as a minimum. If the name of the client is not known (as is generally the case given the anonymous nature of service provision), Health workers must meet their reporting obligations by providing the Department of Community Services with a description of the client. It is important to note that sterile injecting equipment should be made available to any person who is currently involved in injecting drugs, regardless of their age.

You also have reporting obligations regarding children of IDUs if you have reasonable grounds to suspect the children are at risk of harm. Suspicion of risk of harm is based on your observations and knowledge of the situation of the child. If you believe that a child who has an IDU parent or caregiver is at risk of harm, you must make a report to the Department of Community Services.

When making a report, you should discuss any concerns with your team leader and ask for assistance if necessary.

# Appendix



## Brief Guide to Reporting

Health workers have a responsibility to promote the safety, welfare and well-being of children and young people. If you have concerns on reasonable grounds that a child or young person is at risk of harm, you should:

- check the 'Guide to Making a Report to DoCS' in Appendix 4 of this manual
- read the detailed procedures for reporting in chapters 7 and 8.
- consult your supervisor or manager, if appropriate, to help you decide whether to make a report
- provide support and reassurance to the clients because disclosure of abuse is a difficult process for children and young people
- make a report to the DoCS Helpline on **133 627** giving your name, position and Health service
- make sure the child, young person and family are involved in making the report, if safe and appropriate
- if necessary, ensure the safety of the child or young person until contact from DoCS
- arrange for safe transport to a hospital emergency department if the child or young person has injuries
- inform DoCS if the parents or caregivers are unwilling to consent to a medical examination
- inform your supervisor or manager about the report, the action DoCS intends to take if known, and any arrangements for follow up with the child, young person or family
- document the relevant information outlined in chapter 10.
- continue to support the child or young person and, if appropriate, family members.

If you assess that a child or young person may be at risk of harm, irrespective of your supervisor or manager's opinion, you must make a report to the Department of Community Services.

If there are issues relating to a specialist area of work, such as mental health, drug and alcohol, community health or PANOC, please refer to the appropriate section in chapter 18 of this manual.

# 2

## Appendix

### NSW Health Circulars

- 92/21 Patient Information and Consent to Medical Treatment
- 96/73 Access to Department of Health Records by the Child Death Review Team
- 97/58 - Incidents reportable to the Department
- 97/80 - Procedures for recruitment and employment of staff and other persons -vetting and management of allegations and improper conduct
- 2000/100 – Protecting Children and Young People: Recognising and Reporting Suspected Risk of Harm and Responding to Requests from the Department of Community Services
- 98/29 Subpoenas
- 99/18 NSW Health Privacy Code of Conduct
- 99/65 - Ombudsman Amendment (Child Protection and Community Services) Act 1998 - Allegations of child abuse
- 2000/55 - Policy and procedure for employment screening of staff and other persons in child related areas
- 2000/69 - NSW Department of Health policy on employment screening using criminal record checks
- 2000/76 Policy and Procedures for Employment Screening of Staff and other persons in child related areas - amendment to attachments

# Appendix

# 3

<b>Level</b>	<b>Sexual Assault Services Description</b>	
1	No planned service. Able to provide treatment or support prior to referral to designated sexual assault service. Able to assist with transport to referral centre. Formal link with a Level 4 Sexual Assault Service with Policies and procedures in place for referral developed in consultation with Level 4 service. Quality assurance activities(1). Interpreters as per Circular 94/10. Staff trained in relation to recognition and notification as per 97/14. Copies of Recognising and Notifying Child Abuse and Neglect, Procedures for Frontline Health Professionals & A Policy for Protecting Children and Young People from Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect. Copy of Interagency Guidelines for Child Protection Intervention available and all relevant staff aware of and adhere to all documents.	
3	As Level 1 plus specialist counselling staff providing follow up counselling for victim and for non-offending family. This includes individual, group and family counselling. No after hours medical service. Able to assist with transport to Level 4. Formal links with Level 4 for 24 hours crisis counselling and medical care. May provide follow up medical care. Formal quality assurance program(1). Program of community education and professional training provided to other relevant health workers. Training and adherence to Child Protection Policy and Procedures Manual and/or Sexual Assault Service- Policy and Procedures Manual for Adults and relevant interagency protocols. Services without Coordinators must receive supervision and support from Level 4 or Area Sexual Assault Coordinator. May be based in hospitals or community health centre with access to hospital facilities. Pathology Level 1.	
4	As Level 3 plus 24 hour service with counsellor and medical officer on call. Designated coordinator of service. Has medical officer(3) trained in the care of sexual assault victims, including completing forensic protocol(2). Designated area in emergency department or elsewhere in hospital for crisis care, with support services as for Level 3 Emergency Services. Access to specialist care including mental health, surgery, gynaecology and Drug and Alcohol services. Program of community education and professional training. Adherence to Child Protection Policy and Procedures Manual and/or Sexual Assault Service – Policy and Procedures Manual for Adults and Interagency Guidelines for Child Protection Intervention and/or Interagency Guidelines for Responding to Adult Victims of Sexual Assault.	
6	As Level 4 plus conducts research. Extensive program of community education and professional training. Specialist medical staff available for consultation. Colposcopy for children available. Accepts referral from Level 4 for specialist medical assessment. Level 4 Pathology available. Medical officer and paediatric sub-specialists available for consultation. For child sexual assault services Paediatric Medicine and Paediatric Surgery Level 6 on site. For adults gynaecological surgery at Level 5. Provide peer review for medical practitioners.	

(1) See 'Glossary' in Appendix V

(2) Sexual Assault Referral Unit, Medical Protocol or Child Sexual Assault Medical Protocol, Division of Forensic Medicine, Department of Health.

<b>Level</b>	<b>Child Protection Services (PANOC) Description</b>		
1	Reporting and appropriate referral by medical practitioner and health professionals. Management of presenting health problem. Reporting to Department of Community Services (DCS) in accordance with Children (Care and Protection) Act, 1987 and Circular 97/14. Pathology Level 1 and access to Diagnostic Radiology Level 2. Referral for counselling/medical care to next level or appropriate local community health services. No planned PANOC Service. Formal link with Level 4 PANOC and Sexual Assault Service. Interpreters as per Circular 94/10. Staff trained in relation to recognition and notification as per 97/135. Copies of <i>Recognising and Notifying Child Abuse and Neglect, Procedures for Front Line Health Professionals</i> and <i>A Policy for Protecting Children and Young People from Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect</i> . Copy of <i>Interagency Guidelines for Child Protection Intervention</i> available and all relevant staff aware and adhere to all documents.	4	As level 3 plus 24 hour crisis intervention service provided by paediatric/medical officer and health professionals- all with training in dealing with child abuse. Designated PANOC coordinator. Formal link with Level 6 PANOC Service. Designated area in Emergency Department or elsewhere in hospital for crisis care. Referrals from lower levels accepted. Paediatric Medicine Level 4 and Paediatric Surgery Level 3 on site.
3	As Level 1 plus links with on or off site specialist PANOC workers with experience and training in counselling intervention with child victims of physical or emotional abuse or neglect and their carers. Medical service provided by paediatrician/medical officer with paediatric experience. Ongoing medical treatment or monitoring as required. Access to and links with Emergency Departments. Formal link with Level 4 PANOC Service and Level 4 Sexual Assault Service (on or off site). Networks developed between social work department, obstetrics units, paediatric services, mental health, drug and alcohol and community health services. Link and regular meetings with local Department of Community Services and NSW Police Service.	6	As Level 4 plus designated multidisciplinary team consisting of medical services (paediatrician, medical officer), psychiatrist, social worker, psychologist, allied health professionals and nursing staff who will provide 24 hour crisis intervention rostered service from within the team. Has designated director. Has active undergraduate, postgraduate and professional teaching role and conducts research. Clinical pathology available. Medical officer and paediatric specialists available for consultation. Paediatric Medicine Level 6 and Paediatric Surgery Level 6 on site. Provide peer review for medical practitioners. Formal procedures for referring children and families for ongoing counselling intervention back to Level 3 and 4.

# Appendix

# 4

## Checklist for Making a Report to DoCS

A quick checklist is attached for you to go through. By the end of the checklist you should have a clear picture of concerns allow you to make a report under the Children and Young Persons (Care and Protection) Act 1998.

You will also have an understanding of whether you are a mandatory reporter and are obliged under the Children and Young Persons (Care and Protection) Act 1998 to report any child who is at risk of harm or homeless.

### ***Ring 000 immediately if there is a life threatening situation***

This checklist is to assist you if you want to make a report about a child or young person you believe is at risk of harm or who is homeless.

Remember – when making a report please have available all the information you or your organisation has on the child or young person’s situation and their family structure.

1. If you answer **YES to any one of these age groups**, proceed to the next questions.

Do your issues of concern involve:

	YES
One child aged 0 to 15 years OR a group of children affected by the issues of concern (Class of children)	
A young person aged 16 or 17 years	
An unborn infant	

2. If you can answer **YES to all of the following questions you may** make a report to DoCS. Proceed to the next stage to find out if you are a mandatory reporter and **must** make the report. If you answer **NO** to any of the questions, discuss with your supervisor what other options there may be.

	YES
Is the child or young person residing in NSW OR did the issues of concern occur in NSW?	
Can you identify the child or young person? (Minimum: full name, age and home address) OR	
Can you describe them AND their current whereabouts OR give a place they regularly go to (eg: home, school, youth or sporting club etc.) OR can you identify who the class of children are?	
Do you suspect, on reasonable grounds that the child or young person is at risk of harm? (Definition of risk of harm is provided in guide notes) OR Is the child or young person homeless?	

3. You are classified as a Mandatory Reporter if you have any form of paid employment OR deliver a service as part of your professional work OR you are a manager in an organisation in the following fields which deals wholly or in part with children under 16 years:

	YES		YES
Children's Services		Police	
Education		Residential services	
Health care		Community Services	

4. If you can answer YES to any one or more of the following questions AND you are a Mandated Reporter (or you are required to report by your own employer's policies), you MUST contact the Department of Community Services to make a Report. If you are not a Mandated Reporter you may decide, as someone who is concerned about the child or young person, to make a Report.

Risk of Harm: (Definitions of the types of "risk of harm" are listed over page)	YES
Are the child or young person's basic physical needs NOT being met? OR at risk of not being met?	
Are the child or young person's basic psychological needs NOT being met? OR at risk of not being met?	
Does the child or young person require health care? AND Have their parents failed to arrange for necessary health care AND are unable or unwilling to?	
Is the child or young person being physically abused or ill treated? OR at risk of being abused or ill treated?	
Is the child or young person being sexually abused or ill treated? OR at risk of being abused or ill treated?	
Does child or young person live in a household where there is domestic violence? AND As a consequence, are they at risk of suffering serious physical harm OR serious psychological harm?	
Have the child or young person's parents/caregivers behaved in such a way towards them that the child or young person has suffered serious psychological harm? OR is at risk of suffering serious psychological harm?	
Is a child homeless and at risk of harm?	

5. If you answer Yes to the next question, you MUST make a report to DoCS, even if you are not a mandatory reporter:

	YES
Are you providing residential accommodation to a child living away from home without parental permission?	

6. If you answer Yes to the following question about the homelessness of a young person you MAY make a report to DoCS:

	YES
Is a young person homeless AND you have their permission to make a report?	

The following section gives a set of brief references to the Children and Young Persons (Care and Protection) Act 1998 and helps explain what risk of harm means.

## Information from the children and young persons (Care and Protection) Act 1998

- Section 3:** Defines the specific ages of children (0-15 years) and young persons (16-17 years).
- Section 25:** Allows for reports to be made on unborn.
- Section 4:** Defines who the Act applies to. Section 4(c) clarifies that it covers any child or young person who is subject to an event or circumstances (issues of concern) that occurs in NSW.
- Section 27(2):** Notes that the reporter must include the child or young person's name or description.
- Section 27(1):** Classifies what groups of workers are mandatory reporters.

### What is risk of harm?\*

**Section 23(a):** Basic physical or psychological needs not being met (Neglect)

Neglect occurs where there is risk of harm or actual harm to a child or young person caused by the failure to provide the basic physical and emotional necessities of life. Neglect is characterised as a continuum of omissions in the care of a child or young person.

#### Neglect of Basic Physical Needs:

Occurs when a person, whether or not the parent of the child or young person fails to provide the basic staples of life to an adequate degree without reasonable excuse. These basic staples include the following:

- Food
- Safety from harm (which includes issues of adult supervision)
- Clothing
- Physical shelter from the elements
- Hygiene

#### Neglect of Basic Psychological Needs:

May be summarised as the child or young person not receiving sufficient or appropriate interaction or stimulation from their parents or caregivers to allow the child or young person to achieve appropriate attachments with primary carers and others, or allow for their ongoing intellectual, emotional and physical development.

# 5

## Appendix

### CONFIDENTIAL NSW Health

#### Recording Form for the Report of Suspected Risk of Harm Related to the Abuse or Neglect of a Child or Young Person

Name of child or young person \_\_\_\_\_ Age \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Please tick: Male  Female   
Home address \_\_\_\_\_ Postcode \_\_\_\_\_  
Home phone \_\_\_\_\_  
School/Campus/Centre attended by child or young person \_\_\_\_\_  
Names of parents or carers and their relationship to the child or young person \_\_\_\_\_  
Name \_\_\_\_\_ Name \_\_\_\_\_  
Phone No \_\_\_\_\_ Phone No \_\_\_\_\_  
Relationship \_\_\_\_\_ Relationship \_\_\_\_\_  
Aboriginal (  ) Torres Strait Islander (  ) NESB (  ) Language \_\_\_\_\_

#### Report made to the Teleservice Centre:

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time \_\_\_\_\_ AM/PM  
Name of intake officer \_\_\_\_\_

What are the concerns held of harm or risk of harm to the child or young person? \_\_\_\_\_  
\_\_\_\_\_

(Please attach additional information as required)

If this report is being made in relation to a young person, note whether the report has been discussed with the young person, and the views of young person about this report? \_\_\_\_\_  
\_\_\_\_\_

If this a report related to the homelessness of a young person, do you have the young person's permission to make this report? Yes  No

Recommended decision of DoCS Helpline officer about action to be taken, if known \_\_\_\_\_  
\_\_\_\_\_

Call Reference number (allocated to report by the DoCS Helpline)

Health contact person \_\_\_\_\_ Telephone \_\_\_\_\_

Name and Position \_\_\_\_\_

Signature and Date \_\_\_\_\_

# Appendix



## CONFIDENTIAL NSW Health

### Response to Request for Information from the Department of Community Services (Docs)

Name of child, young person or family member: \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Please tick: Male  Female

Name of DoCS Officer Requesting Information: \_\_\_\_\_

#### Relevant Information:

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(Please attach additional information as required)

Is there another Health worker/Service approved for future contact in relation to this matter?

Yes  No  (Please tick)

If Yes, Name of Health worker/Service: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Health worker contacted/completing this form: \_\_\_\_\_

Position \_\_\_\_\_

Health Service Manager \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

# 7

# Appendix

## Instructions for Completion of INTERIM Best Endeavours Forms Management Information Systems Unit

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## Introduction

As part of its responsibility under section 17, 18 and 85 of the Children and Young Persons (Care and Protection) Act 1998, the NSW Health Department has undertaken a number of initiatives to ensure that Best Endeavour responses to Requests for Services from the Department of Community Services are effective and timely.

## The Best Endeavours Intranet Data Collection

A data collection, registration and monitoring system will be implemented at the beginning of March 2001 to monitor the frequency with which Best Endeavour requests are made to Health Services and their effectiveness and impact.

This system will be Intranet based and will feature:

- Statewide central registry of all best endeavours requests.
- Point of contact data entry and updating.
- Coded menus.
- Prompts for key information.

Special features will be:

- Certain data entry triggers for email alerts to the relevant Area Health Service and Community Service Centre at crucial times in the response process.
- A suite of local and AHS based monitoring reports.

In addition, the system will have the capability to eventually:

- Participate in the Human Services Intranet Program.
- Accept direct data input from the Department of Community Services.

## INTERIM Registration and Monitoring

Two forms serve as INTERIM methods for maintaining Area registration and monitoring functions until the Statewide Intranet collection is implemented.

- a) The Response Form for Best Endeavours Requests from The Department of Community Services to be completed at the time of acceptance of the Request for Service from the Department of Community Services.
- b) Update to Best Endeavours Requests for Service to be completed 6 weeks after the date of acceptance of the Request for Service from the Department of Community Services.

Together with the original Request for Service form from the Department of Community Services, they supply the set of information required for Registration and monitoring.

## Feedback about INTERIM system

Comments about the INTERIM forms are encouraged. All feedback will be considered in the design of the Intranet system.

Please send comments to:

Josie Hudson  
Project Officer  
Best Endeavours Data Collection  
Management Information Systems Unit

email: [jhuds@doh.health.nsw.gov.au](mailto:jhuds@doh.health.nsw.gov.au)  
Phone no. (02) 9391 9054  
Fax no. (02) 9391 9070

## Supply of Forms

1. The INTERIM Response Form for Best Endeavours Requests for Service from the Department of Community Services and the INTERIM Update to Best Endeavours Requests for Service are available on the Best Endeavours Data Collection Site on the NSWHealthNet – <http://internal.health.nsw.gov.au/iasd/dm/bedc/>  
NB. A copy of these instructions are also available on this site.
2. Electronic copies are also available from the Department's Management Information Systems Unit. Contact Josie Hudson at [jhuds@doh.health.nsw.gov.au](mailto:jhuds@doh.health.nsw.gov.au)
3. Faxed copies are also available: contact (02) 9391 9054

# Instructions for Completion of INTERIM

## Response Form for Best Endeavours Requests for Service from the Department of Community Services

### Purpose of Form:

1. Provide information to the respective Area Health Service about the timeliness of immediate follow up of a certain Request for Service from the Department of Community Services to a particular Health Service within the Area.
2. Provide follow up information to the particular Community Services Centre about a certain Request for Service that has been received by the Health Service. In particular:
  - a) whether the Request for Service has been accepted or not and
  - b) contact details within the Health Service

### Timeliness:

1. This form is completed as a result of a decision being made about the acceptance or otherwise of a Request for Service from the Department of Community Services to a particular Health Service.
2. This form is then relayed by email or fax to:
  - a) the Area Central Register of Best Endeavours and
  - b) the originating Community Service Centre.
3. The acceptance decision needs to be within 48 hours of receipt of Request for Service at the Health Service.

Question No.	Information Category	Data Element Name	Page No
1	Date	Today's Date	5
2	Details	Health Service Name	5
3		Health Service Type Requested	5
4		DoCS Reference Number	6
5		CIS No(s) of Child(ren) concerned	6
6		Client Date of Birth	7
7		Date of Request	7
8		Date and Time Received at Health Service	7
9		Date and Time Considered by Health Service	8
10		Source of Request	8
11		Outcome of Request: Request accepted	Estimated Time of Service provision
12	Outcome of Request: Request not accepted Service Contact Details	Reason why request not accepted.	9

## 1. Today's Date

Definition: The date on which the form is completed.

Guide for Use:

1. Henceforth, this date will be regarded as the date that the Request for Service was accepted or declined.
2. This is a key field.
3. It is one of the data items used to track the sequence of responses to Best Endeavours Requests.

## 2. Health Service Name.

Definition: The local name by which the provider of the Health Service is known.

Guide for Use:

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

## 3. Health Service Type Requested.

Definition: The type of service requested by the Department of Community Services centre.

Guide for Use:

1. The types of service requested are listed below.
2. One service only to be entered.
3. Enter code only

Code Set:	01 Mental Health Assessment	30 Home Based Care Service
	02 Forensic Medical Examination	31 Indigenous Health Service
	03 Emergency Medical Treatment	32 Men's Health Service
	04 Other Crisis / Trauma Response	33 Mental Health Service
	21 Acute / Post Acute Care Services	34 Oral Health Service
	22 Aged Care Service	35 Palliative Care / Hospice Care Services
	23 Ambulance Service	36 Primary Care Health Service
	24 Child Health Service	37 Public Health Service
	25 Child Protection Service (PANOC)	38 Rehabilitation Service
	26 Counselling Service	39 Respite Care Service
	27 Disability Service	40 Sexual Assault Service
	28 Drug and Alcohol Service	41 Sexual Health Service
	29 Ethnic / Migrant Health Service	42 Women's Health Service
		43 Youth Health Service
		44 Other Health Service ..... Specify

Source of Definition: Community Health Code Set

Source of Information: Request for Service form from DoCS.

## 4. DoCS Reference Number.

Definition: The number assigned by DoCS Helpline to identify a call.

Source of Information: Request for Service form from DoCS.

Guide for Use: 

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavour Requests.

## 5. CIS No(s) of Children concerned.

Definition: The CIS number is the number assigned to a child upon becoming a client of the Department of Community Services.

Guide for Use: 

1. Each CIS number is unique to one child.
2. The client who is the direct subject of the Request for Service may or may not be the child identified at risk of harm.
3. There may be more than one child identified as at risk of harm in one family group.
4. Three spaces have been set aside for three numbers to be entered but if this is not enough, indicate other numbers on the page.

Source of Information: Request for Service form from DoCS.

## 6. Client Date of Birth.

Definition: The date of birth of the client.

Guide for Use: 

1. The client is the person referred.
2. This may be a child at risk of harm or any member of that child's family group.
3. This is a key field.
4. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

## 7. Date of Request

Definition: The Date the Service was Requested by DoCs.

Guide for Use: 

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

## 8. Date and Time Received at Health Service.

**Definition:** The date and time that the Request for Service form is received at the office of the Health Service provider.

**Guide for Use:**

1. The mode of receipt of the form may be encrypted email or fax.
2. This is one of the data items used to track the sequence and timeliness of responses to Best Endeavours Requests.

**Source of Information:** The date stamp on the email or fax.

## 9. Date and Time Considered at Health Service.

**Definition:** The date and time that the request is discussed by the Health Service Manager with a potential worker with regards to timeframes of acceptance or reasons for non acceptance.

## 10. Source of Request.

**Definition:** The originating centre of the Request for Service form from the Department of Community Services.

**Guide for Use:**

1. The types of originating centres are listed below.
2. One type of centre only to be ticked in the box provided.
3. If the origin of the Request for Service form is from DoCS Helpline, the associated Health Service Type Requested is limited to codes 01 to 20.

**List of Items:**

1. Request received from CSC / JIT. Note: specify name.
2. Request received from Helpline.

**Source of Information:** Request for Service form from DoCS.

## 11. Estimated Time of Service Provision.

**Definition:** Having accepted the request for service, the estimated time delay between the date of receipt of request for service and the date when the service is most likely to be able to be offered.

**Guide for Use:**

1. Time periods and other options are listed below.
2. One option only to be ticked in the box provided.
3. If the origin of the Request for Service form is from DoCS Helpline, the associated Health Service Type Requested is limited to codes 01 to 20.

**List of Items:**

1. Service provided before written request
2. Immediately (within 2 days)
3. Between 3 to 7 days
4. Between 1 and 2 weeks
5. Between 2 and 4 week
6. Between 4 and 6 week
7. Between 6 and 8 weeks
8. If waiting time is outside this timeframe: Request has been prioritised on the waiting list for the next vacancy.
9. If waiting time is outside this timeframe: Request has been placed on the waiting list according to priority against other demands.

**Source of Information:** This decision is made at the time that the Health Service Manager and worker confer.

## 12. Reason why request not accepted.

**Definition:** Having not accepted the request for service, the reason why the request was deemed not acceptable.

**Guide for Use:**

1. One of the listed items only needs to be checked.
2. Specify reasons where prompted.

**List of Items:**

1. Service requested is not currently provided due to staff vacancy
2. Service requested is not consistent with the service responsibilities.  
Note: specify inconsistency.
3. Providing the service would prejudice the discharge of the service functions.  
Note: specify reason.
4. Service requested is not currently provided due to another reason.  
Note: specify reason.
5. Request has been transferred to an alternate Health Service which has agreed to accept the request.  
Note:
  1. Enter date transferred to alternate Health Service.
  2. Enter alternate service details in 'Service Contact Details' box.

**Source of Information:** This decision is made at the time that the Health Service Manager and worker confer.

### Service Contact Details.

**Guide for use:** This information is provided to facilitate contact by DoCS.

# Instructions for Completion of INTERIM

## Update to Best Endeavours Requests for Service

### Purpose of Form:

1. Provide information to the respective Area Health Service about the timeliness of service provision following the acceptance of a Request for Service from the Department of Community Services to a particular Health Service within the Area.

### Timeliness:

1. This form is completed 6 weeks after accepting a Request for Service from the Department of Community Services to a particular Health Service.
2. This form is then relayed by email or fax to the Area Central Register of Best Endeavours

Question No.	Information Category	Data Element Name	Page No
1	Date	Today's Date.	11
2	Details	Health Service Name.	11
3		DoCS Reference Number.	11
4		Client Date of Birth.	11
5		Date of Request.	11
6		Planning Meeting / Process	Date of Planning Meeting / Process.
7	First Client Contact	Date Client First Seen.	12
8		Service Provided to.	12
9		Time between Request Received at Health Service and Client first seen.	12
10		Time between Planning Meeting / Process and Client first seen.	13
11	Where Service is Not Provided	Reason for Service Not Provided.	13

### 1. Today's Date

Definition: The date on which the form is completed.

Guide for Use: This date should be 6 weeks after completing the INTERIM Response Form for Best Endeavours Requests for Service from the Department of Community Services.

## 2. Health Service Name.

Definition: The local name by which the provider of the Health Service is known.

Guide for Use: 

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

## 3. DoCS Reference Number

Definition: The number assigned by DoCS Helpline to identify a call.

Guide for Use: 

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

## 4. Client Date of Birth

Definition: The date of birth of the client.

Guide for Use: 

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.
3. The client is the person referred.
4. The referred client may or may not be a child at risk of harm.

Source of Information: Request for Service form from DoCS.

## 5. Date of Request

Definition: The date the service was requested by DoCs.

Guide for Use: 

1. This is a key field.
2. This is one of the data items used to track the sequence of responses to Best Endeavours Requests.

Source of Information: Request for Service form from DoCS.

## 6. Date of Planning Meeting / Process.

Definition: The date a planning meeting or a planning process in partnership with DoCS occurs.

Guide for Use: This is the meeting / process organised by DoCS after receiving an acceptance from a Health Service for a Request for Service.

## 7. Date Client first seen.

Definition: Where the service is provided, the date that the client is seen for the first time since the planning meeting / process occurs.

## 8. Service provided to.

Definition: Where the service is provided, the nature of the relationship of the client to the identified child(ren) at risk of harm.

List of Items:

1. Child at risk of harm
2. Young person at risk of harm
3. Sibling of Child / young person at risk of harm
4. Parent / Carer
5. Other Family member

Source of Information: This decision is made at the time that the Health Service Manager and worker confer.

## 9. Time between Request Received at Health Service and Client first seen.

Definition: Where the service is provided, the time period that has elapsed between the date that the Health Service receiving the request to the date that the client was first seen.

List of Items:

1. Immediately (within 2 days)
2. Between 3 and 7 days
3. Between 1 and 2 weeks
4. Between 2 and 4 weeks
5. Between 4 and 6 weeks
6. Between 6 and 8 weeks

Source of Information: Case notes.

## 10. Time between Planning Meeting / Process and Client First Seen.

Definition: Where the service is provided, the time period that has elapsed between the date of the occurrence of a planning meeting / process and the date that the client was first seen.

List of Items:

1. Immediately (within 2 days)
2. Between 3 and 7 days
3. Between 1 and 2 weeks
4. Between 2 and 4 weeks
5. Between 4 and 6 weeks

Source of Information: Case notes.

## 11. Reason for Service not provided.

Definition: Where the service is not provided, the reason for non provision.

Guide for Use: 

1. One of the listed items needs to be checked.
2. Specify reasons where prompted.

List of Items: 

1. DoCs did not proceed with referral
2. Planning meeting / process still pending
3. Appointment made but client not yet attended
4. Client still on waiting list
5. Service not proceeded with due to unresolved safety concerns.  
Note: specify date this has been discussed with a DoCS Officer.
6. Attempts to contact the client unsuccessful.  
Note: specify date(s) of attempted contact.
7. Service not proceeded with for other reason.  
Note: specify details.

Source of Information: Case notes.

## Response Form for Best Endeavours Requests for Service from the Department of Community Services

This form must be provided to the Central Register and to the DoCS Centre from where the request originated.

1. Today's Date: \_\_/\_\_/\_\_\_\_

### Details:

2. Health Service Name: \_\_\_\_\_

3. Health Service Type Requested: \_\_\_\_\_

(Community Health Code List)

4. DoCS Reference Number: \_\_\_\_\_

5. CIS No(s) of Child(ren) concerned:  
\_\_\_\_\_

6. Client Date of Birth: \_\_/\_\_/\_\_\_\_

7. Date of Request: \_\_/\_\_/\_\_\_\_

8. Date and time received at Health Service:  
\_\_/\_\_/\_\_\_\_ \_\_ (24hr) \_\_ (min)

9. Date and time considered by Health Service:  
\_\_/\_\_/\_\_\_\_ \_\_ (24hr) \_\_ (min)

10. Source of Request:

Request received from CSC / JIT.

Name: \_\_\_\_\_

OR

Request received from DoCS Helpline.

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Service Manager

## Outcome of Request

Contact with DoCS must be made within 2 working days of receiving the request.

### Request Accepted.

11. Estimated time of service provision:

Service provided before written request  
Immediately (within 2 days)  
Between 3 – 7 days  
Between 1 and 2 weeks  
Between 2 and 4 weeks  
Between 4 and 6 weeks  
Between 6 and 8 weeks

OR If waiting time is outside this timeframe:

Request has been prioritised on the waiting list for the next vacancy. OR  
Request has been placed on the waiting list to be assessed according to priority against other demands.

12. Reason why Request Not Accepted.

Service requested is not currently provided due to staff vacancy. OR  
Service requested is not consistent with the service responsibilities.

Specify \_\_\_\_\_ OR

Providing the service would prejudice the discharge of the service functions.

Specify: \_\_\_\_\_ OR

Service requested is not currently provided due to other reason.

Specify: \_\_\_\_\_ OR

Request has been transferred to an alternate Health Service which has agreed to accept the request. Details are shown below.

Date Transferred: \_\_/\_\_/\_\_\_\_

### Service Contact Details:

Service Name \_\_\_\_\_

Contact Name \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

email \_\_\_\_\_

## Response Form for Best Endeavours Requests for Service from the Department of Community Services

This form must be provided to the Central Register and to the DoCS Centre from where the request originated.

### Health Service Type

- 01 Mental Health Assessment
- 02 Forensic Medical Examination
- 03 Emergency Medical treatment
- 04 Other Crisis / trauma response
- 21 Acute / Post Acute Care Services
- 22 Aged Care Service
- 23 Ambulance Service
- 24 Child Health Service
- 25 Child Protection Service (PANOC)
- 26 Counselling Service
- 27 Disability Service
- 28 Drug & Alcohol Service
- 29 Ethnic / Migrant Health Service
- 30 Home Based Care Service
- 31 Indigenous Health Service
- 32 Men's Health Service
- 33 Mental Health Service
- 34 Oral Health Service
- 35 Palliative Care / Hospice Care Services
- 36 Primary Care Health Service
- 37 Public Health Service
- 38 Rehabilitation Service
- 39 Respite Care Service
- 40 Sexual Assault Service
- 41 Sexual Health Service
- 42 Women's Health Service
- 43 Youth Health Service
- 44 Other Health Service.....Specify

## Update to Best Endeavours Requests for Service

This information must be provided to the Central Register six weeks after accepting a the Request for Service.

1. Today's Date: \_\_/\_\_/\_\_\_\_

### Details:

2. Health Service Name \_\_\_\_\_

3. DoCS Reference Number \_\_\_\_\_

4. Client Date of Birth: \_\_/\_\_/\_\_\_\_

5. Date of Request: \_\_/\_\_/\_\_\_\_

6. Date of Planning Meeting / Process: \_\_/\_\_/\_\_\_\_

### Outcome of Contact with Client:

A: Where Service is Provided:

7. Date client first seen: \_\_/\_\_/\_\_\_\_

8. Service provided to:

Child at risk of harm

Young person at risk of harm

Sibling of child / young person at risk of harm

Parent / carer

Other Family Member

9. Time between Request Received at Health Service and Client first seen.

Immediately (within 2 days)

Between 3-7 days

Between 1 to 2 weeks

Between 2 to 4 weeks

Between 4 to 6 weeks

Between 6 to 8 weeks

10. Time between Planning Meeting / Process and Client first seen.

Immediately (within 2 days)

Between 3 to 7 days

Between 1 to 2 weeks

Between 2 to 4 weeks

Between 4 to 6 weeks

B: Where Service is Not Provided:

11. Reason for Service Not Provided:

DoCS did not proceed with referral. OR

Planning meeting / process still pending. OR

Appointment made but client not yet attended. OR

Client still on waiting list. OR

Service not proceeded with due to unresolved safety concerns.

Date discussed with DoCS: \_\_/\_\_/\_\_\_\_ OR

Attempts to contact client unsuccessful.

Date(s) of attempted contact:

\_\_/\_\_/\_\_\_\_                      \_\_/\_\_/\_\_\_\_

\_\_/\_\_/\_\_\_\_                      \_\_/\_\_/\_\_\_\_

Service not proceeded with for other reason.

Specify \_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_

Name: \_\_\_\_\_

Service Manager

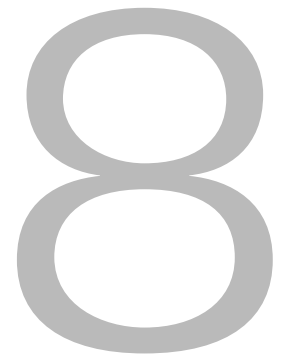
## Response Form for Best Endeavours Requests for Service from the Department of Community Services

This form must be provided to the Central Register and to the DoCS Centre from where the request originated.

### Health Service Type

- 01 Mental Health Assessment
- 02 Forensic Medical Examination
- 03 Emergency Medical treatment
- 04 Other Crisis / trauma response
- 21 Acute / Post Acute Care Services
- 22 Aged Care Service
- 23 Ambulance Service
- 24 Child Health Service
- 25 Child Protection Service (PANOC)
- 26 Counselling Service
- 27 Disability Service
- 28 Drug & Alcohol Service
- 29 Ethnic / Migrant Health Service
- 30 Home Based Care Service
- 31 Indigenous Health Service
- 32 Men's Health Service
- 33 Mental Health Service
- 34 Oral Health Service
- 35 Palliative Care / Hospice Care Services
- 36 Primary Care Health Service
- 37 Public Health Service
- 38 Rehabilitation Service
- 39 Respite Care Service
- 40 Sexual Assault Service
- 41 Sexual Health Service
- 42 Women's Health Service
- 43 Youth Health Service
- 44 Other Health Service.....Specify

# Appendix



## Information Request Form

(to be used by agencies seeking information from DoCS) (Current at December 2000)

Section 248 of the Children and Young Persons (Care and Protection) Act 1998 provides for the exchange of information regarding the safety, welfare and well being of a particular child or young person or class of children or young persons.

The Act authorises DoCS to use discretion in the decision to provide information in response to this request. DoCS will provide the requested information only if it is determined by DoCS that the provision of information is in the best interests of the child or young person, or the class of children or young persons.

To \_\_\_\_\_  
(name of DoCs position) \_\_\_\_\_

At \_\_\_\_\_  
(office / CSC) \_\_\_\_\_

From \_\_\_\_\_  
(name of person requesting information) \_\_\_\_\_

At \_\_\_\_\_  
(Government department or agency) \_\_\_\_\_

This request is made in regard to:  
\_\_\_\_\_  
name of child/ren or young person/s  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_  
Gender:           M       F

Information is sought regarding the following persons:

Name	Relationship to child/young person	DOB

### Comment

(include any relevant information which may assist the agency in identifying the subject of the information required)

Specific information is requested in regard to:

- current and/or past history of involvement with the child, young person and/or their family
- family/ relationship dynamics ( if known)
- attitude of the child, young person and/ or family to agency/service involvement
- other details required

\_\_\_\_\_  
\_\_\_\_\_

Please provide the requested information

- by phone
- by fax\*
- in the form of a written report.

\* Care should be taken in providing sensitive information via fax. This procedure must be negotiated with and agreed to by the agency providing the information.

The information is required by \_\_\_\_\_ date \_\_\_\_\_

This information is sought in relation to the following issues of concern held for the above mentioned child/young person or class of children or young persons:

\_\_\_\_\_  
\_\_\_\_\_

Client consent should be sought in regard to the exchange of information. However, the Act authorises the exchange of information under section 248 without consent. Consent requires that the person has been given adequate information in a manner and language that they understand.

The child/ young person/ parent/carer has given consent for the release of information requested in this form. or

The child/ young person/ parent/carer has not given consent for the release of information requested in this form. The reason for this is:OR

The principle of participation requires that clients be adequately informed about decisions and processes that affect their lives. All information must be imparted in a manner and language that is understood by the persons involved.

The child or young person's parent/carer has been informed of this request for information? or

The child or young person's parent/carer has not been informed of this request for information? The reason for this is:

Delegated Officer of the Department of Community Services

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details of the person making the request.

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

# 9

## Appendix

### The Impact and Dynamics of Child Abuse and Neglect

The developmental years of childhood and adolescence play a critical role in establishing the foundations, skills and abilities needed for optimal health throughout life. The experience of abuse and neglect can have a devastating impact on the health and well-being of children and young people. This may result in a legacy of physical and psychological disabilities that are carried on into adult life:

*"Adult problems in self-perception and self-acceptance, relationship to others, and world view can often be understood as the logical consequences of childhood maltreatment."* (Finkelhor, 1992, ix)

Whatever form it takes, abuse or neglect experienced in childhood can have severe impacts because of the vulnerability and dependency of children. While the family is for most children a place of nurture and security, the abused or neglected child or young person is trapped in an impossible position:

*"Like other victims, abused children experience significant psychological distress and dysfunction. Unlike adults, however, they are traumatized during the most critical period of their lives: when assumptions about self, others, and the world are being formed; when their relations to their own internal states are being established; and when coping and affiliative skills are first acquired. Such post traumatic reactions can also have an impact on subsequent psychological and social maturation."* (Briere, 1992, 17)

Many of the difficulties reported by adult survivors of childhood abuse or neglect can be understood as the outcome of a child or young person's attempts to cope in a situation of helplessness and fear. However these coping mechanisms, so essential to survival in childhood, become problems in themselves in adult life.

In addition to the suffering caused to those affected, there is a developing view that child abuse is inextricably linked with many major social problems currently confronting the community.

*"If the nation is serious about the prevention of mental health problems, substance abuse, and crime, it must learn about child abuse and neglect"* (Melton and Flood, 1994, 2).

At the same time there is emerging evidence that not all those abused in childhood go on to suffer the type of ill effects identified. Identifying the factors that mediate the impact of abuse is of crucial importance to both the prevention and treatment of child abuse (Werner, 1989; Wolff, 1995).

Awareness of the potential long-term impact of all forms of child abuse and neglect adds urgency to our efforts to both prevent abuse and neglect and, if this is not possible, to recognise abuse where it is occurring and intervene effectively to prevent the development of long term problems and suffering.

While all forms of abuse have similarities, particularly in their long term impact on victims and in the core dynamic of the entrapment caused by the child's dependence, immaturity and vulnerability, it is suggested by some experts that identifying the differences between the dynamics of the various forms of abuse is also important if prevention and intervention are to be accurately targeted and effective (Scott, 1995). However, it is also important to recognise that some children are subjected to multiple forms of abuse and children and young people who are experiencing abuse are often also witnessing domestic violence (Tomison, 2000). Recognition of one type of child abuse or domestic violence should therefore alert Health workers to the possibility that other forms of abuse may be occurring. Australian and overseas research has established that in up to 66% of families where child abuse risk indicators are present, domestic violence in the household was also identified. (Farmer and Owen, 1995; Stanley and Goddard, 1993).

In addition, children who are exposed to domestic violence have been found to experience a similar trauma response as other abused or neglected children (Stephens, 1999; Edleson, 1999).

Child sexual abuse differs in some significant ways from other forms of child abuse and neglect. For example while the ability to predict any form of abuse is far from perfect, it is even more difficult in the case of child sexual abuse. Neither potential victims nor potential perpetrators are able to be reliably identified (Daro, 1994). In addition, while perpetrators of child sexual abuse are more likely to be known to the child than to be strangers, they are not limited to parents or caregivers as is most often the case with other forms of abuse. Sexual offenders against children and young people represent the broad spectrum of adults and adolescents who have contact with children. They include siblings, extended family members, neighbours, family friends, clergy and teachers. These features of child sexual abuse shape the types of prevention activities which are possible.

Child sexual assault is a crime. Intervention by the criminal justice system is more common with child sexual assault than with other forms of child abuse or neglect. The involvement of child victims and non-offending family with the criminal justice system requires a specialist response by Health workers who understand the legal system and its impact on children and non-offending family members and can provide appropriate preparation and support.

Because of the intractable nature of sexual offending, separating offenders from victims and potential child victims is essential to ensure safety. In contrast, the approach to intervention with physical abuse less frequently involves criminal prosecution except if the abuse includes serious physical assault or is sadistic. If the child's safety can be assured, it is more common in cases of physical abuse for the child to remain in the care of parents and caregivers. They are then offered a range of services, such as counselling, parenting education and home visiting programs, to help them to care for the child.

Current approaches to physical abuse and neglect emphasise the development of partnerships with parents to empower them to function as nurturing, confident parents. This approach is possible because many parents and caregivers actively seek help with parenting, sometimes because of fears of harming a child.

An important area of difference in types of abuse and neglect is gender. For example, for states where Australian data is available, women were more likely to neglect their children (NSW Child Protection Council, 1994). This reflects the over-representation of female single parent families in the substantiated cases of neglect, relative to their proportion in the population, and highlights the pressure on single parents in child rearing.

In addition, women subjected to violence from their male partners are more likely to abuse their children (James, 1994).

In contrast, the overwhelming majority of child sexual assault offenders are male and gender has been identified as important in understanding and responding to child sexual abuse (Marshall, Laws & Barbaree, 1990). Theory development has addressed aspects of male socialisation, such as a lesser degree of empathy for children, which may contribute to child sexual abuse and may suggest directions for prevention (Finkelhor and Lewis, 1988). There is some evidence to suggest that women do feature as both offenders of child sexual assault and domestic violence, however the vast majority of offenders are male (Finkelhor, Hotaling, Lewis & Smith, 1990; NSW Health, 1997).

Until recently, theory, research and practice have understated gender differences in the occurrence of physical abuse, despite evidence that men are responsible for at least half of all physical abuse and for the majority of the most serious physical abuse (Tomison, 1996; Leventhal, 1996). Much of the work to date has concentrated on working with mothers of abused children:

*"The failure of workers and researchers to engage father figures in casework or research has been attributed to sexist, cultural and legal assumptions whereby mothers having any role in the care of their children are automatically assumed to be accountable." (Tomison, 1996, 8)*

The issue of gender is only one example of the different dynamics in the various forms of child abuse and neglect. NSW Health recognises that effective prevention and intervention in child abuse must be based on a sound understanding of the similarities and differences between the various forms of abuse and neglect.

# 10

## Appendix

### **NSW Health Mental Health Tribunal**

PO Box 2019  
BORONIA PARK NSW 2111  
Tel (02) 9816 5955  
Fax (02) 9817 4543

### **NSW Pre-Trial Diversion of Offenders Program**

Cedar Cottage  
PO Box 45  
WESTMEAD NSW 2145  
Tel (02) 9891 6199  
Fax (02) 9891 1080

### **Pharmaceutical Services Branch – NSW Health**

Building 29  
Gladesville Hospital Campus  
Cnr Victoria and Punt Roads  
GLADESVILLE NSW 1675  
Tel (02) 9879 3214  
Fax (02) 9859 5165

### **Department of Community Services**

164-174 Liverpool Road  
ASHFIELD NSW 2131  
Tel (02) 9716 2222  
Fax (02) 9789 5486  
DX21212 Ashfield  
[www.community.nsw.gov.au](http://www.community.nsw.gov.au)

### **Education Centre Against Violence**

Locked Bag 7118  
PARRAMATTA BC NSW 2150  
Tel (02) 9840 3737  
Fax (02) 9840 3754  
Email: [ecav@wsahs.nsw.gov.au](mailto:ecav@wsahs.nsw.gov.au)

### **Guardianship Tribunal**

Locked Bag 9  
BALMAIN NSW 2041  
Tel (02) 9555 8500  
Fax (02) 9555 9049

### **NSW Health Department**

Staff Records Management Unit  
PO Box 961  
North Sydney NSW 2059  
Tel (02) 9219 7494  
Fax (02) 9211 8861

### **NSW Commission for Children and Young People**

Level 2  
407 Elizabeth Street  
SURRY HILLS NSW 2010  
Tel (02) 9286 7276  
Fax (02) 9286 7267  
[www.kids.nsw.gov.au](http://www.kids.nsw.gov.au)

### **Victims of Crime Bureau**

Locked Bag A5010  
SYDNEY SOUTH NSW 1235  
Tel (02) 9374 3005 or 1800 633 063  
Fax (02) 9374 3020  
[www.lawlink.nsw.gov.au/vcb](http://www.lawlink.nsw.gov.au/vcb)

### **NSW Department of Health Web Site**

[www.health.nsw.gov.au](http://www.health.nsw.gov.au)

# Appendix



## Glossary

(Adapted from the Interagency Guidelines for Child Protection Intervention 2000)

**adolescent:** A person at the stage of human development between puberty and adulthood.

**assault:** is any act done intentionally or recklessly which causes another person to fear immediate and unlawful violence. The term assault usually includes battery but assault may occur without battery. The act must be a hostile one. An assault can be reckless with foresight of the likelihood of inflicting injury. Battery is the intentional or reckless application of force.

**developmental assessment:** An assessment by a health or education professional of the child's physical, social or cognitive development and functioning.

**child and family assessment:** An assessment of the functioning of a particular family in relation to meeting the needs of a child or young person. The assessment may include an assessment of the child or young person's relationship with family members.

**psychological assessment:** An assessment by a psychologist, child psychiatrist, social worker, guidance or education worker of a child's neurological, intellectual, social, emotional, developmental or scholastic functioning.

**risk assessment:** An assessment of the likelihood of further risk of harm to a child or young person from abuse or neglect, based on the seriousness and circumstances of past and current risk of harm, the capacity of adults to protect the child or young person and the age and vulnerability of the child or young person.

**caregiver:** A person who, while not a parent of the child, has actual custody of the child. Caregivers may provide the care with or without fee or reward and can include relatives, friends or acquaintances of a parent, residential care workers, child care workers, youth workers, nursing staff and foster parents.

**child:** Any person under 16 years of age, except where otherwise stated.

**class of children or young people:** More than one child or young person who may be at risk of harm because of association with a person or a situation causing risk of harm from abuse and neglect.

**female genital mutilation:** According to the World Health Organisation, female genital mutilation includes all procedures that involve partial or total removal of the female external genitalia, and/or injury to female genital organs for cultural or other non-therapeutic reasons.

**Health service manager:** The manager, director or team leader of any unit or facility operated by an Area Health Service, Corrections Health Service, Ambulance Service or the Children's Hospital at Westmead.

**Health worker/employee:** In this manual, the term Health worker or Health employee covers employees both paid and unpaid within the Public Health System according to the purposes of the Health Services Act 1997, 154 section 6, Chapter 2 Part 6.

**interpreter:** Accredited language or sign interpreters and people experienced in the use of facilitated communication techniques for people with disabilities.

**investigation:** has different meanings depending on the context.

In matters where there is risk of harm or a criminal offence, it is a process for gathering information in response to a report about risk of harm by officers of the Department of Community Services or by police officers in response to an allegation of risk of harm or a suspected criminal offence against a child. An investigation may include interviews and other enquiries into all of the child's circumstances and any risk to their future safety and welfare.

In matters involving an allegation of child abuse against an employee, the term 'agency investigation' is used. This is a broad fact finding process where a designated agency carries out some form of inquiry and assessment and possible adjudication of the allegation.

**mandatory reporting:** is the act of a person mandated under s27 of the Children and Young Persons (Care and Protection) Act reporting that they suspect a child is at risk of harm.

**out-of-home care:** means residential care and control of a child or young person at a place other than their usual home and by a person who is not the child or young person's parent or relative. It can include staying with friends and acquaintances, foster care, residential care, shared family care and other forms of substitute care.

**parent:** Any person having parental responsibility for a child or young person.

**parental responsibility:** All the duties, powers, responsibility and authority which parents have by law in relation to their children.

**practitioner:** A person who works with or without fee or reward in any government or non-government setting for the benefit of children. It includes police officers, teachers, psychologists, welfare workers, health workers and counsellors.

**protective intervention:** The action taken by agencies to protect a child or young person from abuse and neglect by providing care, services and support or apprehending and prosecuting those responsible for their abuse.

**reasonable grounds:** are grounds which would cause a reasonable person to form a judgement of risk of harm having regard to the circumstances of the individual case. These include the nature and seriousness of the allegations made, the age and physical condition of the child, any corroborative evidence which exists, and other relevant information.

**report:** Information provided, in accordance with sections 23, 25 or 27 of the Child and Young Persons (Care and Protection) Act 1998, by a person who forms the belief on reasonable grounds that there are current concerns for a child, young person or a class of children due to risk of harm from abuse or neglect.

**reporting:** The act of making a report to the Department of Community Services.

**risk of harm:** Agencies and practitioners are required to make judgements about risk of harm to a child or young person from child abuse or neglect. The assessment requires an evaluation of both the degree of harm and its probability and must take into account the age and vulnerability of the child or young person.

**young person:** Any person who is aged 16 years or above but who is under 18 years.

# Appendix

# 12

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